State of Rhode Island and Providence Plantations
OFFICE OF THE HEALTH INSURANCE COMMISSIONER

233 Richmond Street
Providence, RI 02903

NOTICE OF PROPOSED REGULATION AND NOTICE OF RESCHEDULING OF PUBLIC HEARING

Notice is hereby given, in accordance with R.I. Gen. Laws §§ 42-14-17 and 42-35-3, that the Office of the Health Insurance Commissioner ("OHIC") proposes to enact the following Proposed Regulation:

Regulation 2 — Powers and Duties of the Office of the Health Insurance Commissioner

The Proposed Regulation is designed meet the requirements established by the OHIC Purposes Statute, set out at R.I. Gen. Laws § 42-14.5-2.

Notice is also hereby given, in accordance with R.I. Gen. Laws § 42-35-2, that the the OHIC will reschedule a public hearing on the proposed regulation, originally scheduled for 4:15 P.M. on September 19, 2006 in the Main Hearing Room of the Department of Business Regulation, 233 Richmond Street, Providence, Rhode Island 02903, regarding the Proposed Regulation. The hearing will instead be held at 10:00 A.M. on October 17, 2006 in the Main Hearing Room of the Department of Business Regulation, 233 Richmond Street, Providence, Rhode Island 02903.

Copies of the Proposed Regulation are on file at the OHIC and copies may be obtained from the OHIC, 233 Richmond Street, Providence, Rhode Island 02903 during normal working hours on regular business days or by mail upon request. The Proposed Regulation may also be accessed at www.dbr.state.ri.us/health_insurance.html.

In the decision of the OHIC to develop the Proposed Regulation, consideration was given to overlapping approaches, overlap and duplication with other statutory and regulatory provisions and economic impact on small business and cities and towns.

All interested persons may submit their views, data or arguments regarding the OHIC's Proposed Regulation, including information relating to alternative approaches, duplication or overlap with other state rules or regulations and the economic impact of the Proposed Regulation on small business and/or cities and towns, orally at the public hearing or in writing, either by delivering the same in person or United States mail with postage pre-paid thereon to OHIC, 233 Richmond Street, Providence, Rhode Island 02903, attention John Aloysius Cogan Jr., Hearing Officer, or by e-mail to jcogan@dbr.state.ri.us.

ALL SUBMISSIONS MUST BE RECEIVED NOT LATER THAN OCTOBER 17, 2006, AT 10:00 A.M.

The hearing room is accessible to the handicapped. Individuals requesting interpreter services for the hearing impaired must notify the Executive Assistant for Program and Policy Review at (401) 222-7866 or TDD 711 not less than ninety-six (96) hours in advance of the hearing date.

Christopher F. Koller
Health Insurance Commissioner

State of Rhode Island and Providence Plantations
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
233 Richmond Street
Providence, RI 02903

OFFICE OF THE HEALTH INSURANCE COMMISSIONER REGULATION 2

POWERS AND DUTIES OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER

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Section 1 ***Authority***

This regulation is promulgated pursuant to R.I. Gen. Laws §§ 42-14.5-1 *et seq.*, 42-14-5, 42-14-17 and 42-35-1 *et seq.*

Section 2 ***Purpose and Scope***

When creating the Office of the Health Insurance Commissioner (OHIC or Office), the General Assembly created a list of statutory purposes for the OHIC at R.I. Gen. Laws § 42-14.5-2 (the OHIC Purposes Statute). In order to meet the requirements established by the OHIC Purposes Statute, the OHIC has developed this regulation, which is designed to:

- ensure effective regulatory oversight by the OHIC;
- provide guidance to the state's health insurers, health care providers, consumers of health insurance, consumers of health care services and the general public as to how the OHIC will interpret and implement its statutory obligations; and
- implement the intent of the General Assembly as expressed in the OHIC Purposes Statute.

Section 3 ***<u>Definitions</u>***

As used in this regulation:

(a) "Affiliate" has the same meaning as set out in the first sentence of R.I. Gen. Laws § 27-35-1(a). An "affiliate" of, or an entity or person "affiliated" with, a specific entity or person, is an entity or person who directly or indirectly through one or more intermediaries controls, or is controlled by, or is under common control with, the entity or person specified.

(b) "Commissioner" means the Health Insurance Commissioner.

(c) "Examination" has the same meaning as set out in R.I. Gen. Laws § 27-13.1-1 *et seq*.

(d) "Health insurance" shall mean "health insurance coverage," as defined in R.I. Gen. Laws §§ 27-18.5-2 and 27-18.6-2, "health benefit plan," as defined in R.I. Gen. Laws § 27-50-3 and a "medical supplement policy," as defined in R.I. Gen. Laws § 27-18.2-1 or coverage similar to a Medicare supplement policy that is issued to an employer to cover retirees.

(e) "Health insurer" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a non-profit hospital service corporation, a non-profit medical service corporation, a non-profit dental service corporation, a non-profit optometric service corporation, a domestic insurance company subject to chapter 1 of title 27 of the General Laws that offers or provides health insurance coverage in the state and a foreign insurance company subject to chapter 2 of title 27 of the General Laws that offers or provides health insurance coverage in the state.

(f) "Holding company system" has the same meaning as set out in R.I. Gen. Laws § 27-35-1 *et seq*.

Section 4 ***<u>Discharging Duties and Powers</u>***

The Commissioner shall discharge the powers and duties of the Office to:

(a) Guard the solvency of health insurers;

(b) Protect the interests of the consumers of health insurance;

(c) Encourage fair treatment of health care providers by health insurers;

(d) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and

(e) View the health care system as a comprehensive entity and encourage and direct health insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

Section 5 ***<u>Guarding the Solvency and Financial Condition of Health Insurers</u>***

(a) The solvency of health insurers must be guarded to protect the interests of insureds, health care providers, and the public generally.

(b) Whenever the Commissioner determines that

(i) the solvency or financial condition of any health insurer is in jeopardy or is likely to be in jeopardy;

(ii) any action or inaction by a health insurer could adversely affect the solvency or financial condition of that health insurer;

(iii) the approval or denial of any regulatory request, application or filing by a health insurer could adversely affect the solvency or financial condition of that health insurer; or

(iv) any other circumstances exist such that the solvency or financial condition of a health insurer may be at risk

the Commissioner shall, in addition to exercising any duty or power authorized or required by titles 27 or 42 of the General Laws related specifically to the solvency or financial health of a health insurer, act to guard the solvency and financial condition of a health insurer when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

(c) When making a determination as described in subsection (b) of this section or when acting to guard the solvency of a health insurer, the Commissioner may consider and/or act upon the following solvency and financial factors, either singly or in combination of two or more:

(i) any appropriate financial and solvency standards for the health insurer, including those set out in title 27 of the General Laws and implementing regulations;

(ii) the investments, reserves, surplus and other assets and liabilities of a health insurer;

(iii) a health insurer's use of reinsurance, and the insurer's standards for ceding, reporting on, and allowing credit for such reinsurance;

(iv) a health insurer's transactions with affiliates, agents, vendors, and other third parties to the extent that such transactions adversely affect the financial condition of the health insurer;

(v) any audits of a health insurer by independent accountants, consultants or other experts;

(vi) the annual financial statement and any other report prepared by or on behalf of a health insurer related to its financial position or financial activities;

(vii) a health insurer's transactions within an insurance holding company system;

(viii) whether the management of a health insurer, including its officers, directors, or any other person who directly or indirectly controls the operation of the health insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in the position;

(ix) the findings reported in any financial condition or market conduct examination report and financial analysis procedures;

(x) the ratios of commission expense, general insurance expense, policy benefits and reserve increases as to annual premium and net investment income, which could lead to an impairment of capital and surplus;

(xi) concerns that a health insurer's asset portfolio, when viewed in light of current economic conditions, is not of sufficient value, liquidity, or diversity to ensure the health insurer's ability to meet its outstanding obligations as such obligations mature;

(xii) the ability of an assuming reinsurer to perform and whether the health insurer's reinsurance program provides sufficient protection for the health insurer's remaining surplus after taking into account the health insurer's cash flow and the classes of business written and the financial condition of the assuming reinsurer;

(xiii) the health insurer's operating loss in the last twelve month period or any shorter period of time, including but not limited to net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders, is greater than fifty percent of the health insurer's remaining surplus as regards policyholders in excess of the minimum required;

(xiv) whether any affiliate, subsidiary, or reinsurer of a health insurer is insolvent, threatened with insolvency, or delinquent in the payment of its monetary or other obligations;

(xv) any contingent liabilities, pledges, or guaranties of a health insurer that either individually or collectively involve a total amount which in the opinion of the Commissioner may affect the solvency of the health insurer;

(xvi) whether any person, firm, association, or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a health insurer, is delinquent in the transmitting to, or payment of, net premiums to the insurer;

(xvii) the age and collectibility of a health insurer's receivables;

(xviii) whether the management of a health insurer has

(A) failed to respond to inquiries by the Commissioner, the Department of Business Regulation, the Department of Health, the Department of the Attorney General, any other state or federal agency relative to the financial condition of the health insurer;

(B) furnished false and misleading information concerning an inquiry by the Commissioner, the Department of Business Regulation, the Department of Health, the Department of the Attorney General, any other state or federal agency regarding the financial condition of the health insurer; or

(C) failed to make appropriate disclosures of financial information to the Commissioner, the Department of Business Regulation, the Department of Health, the Department of the Attorney General, any other state or federal agency, or the public.

(xix) whether the management of a health insurer either has filed any false or misleading sworn financial statement, or has released a false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the health insurer;

(xx) whether a health insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner; and

(xxi) whether a health insurer has experienced or will experience in the foreseeable future cash flow and/or liquidity problems.

(d) The factors enumerated in subsection (c) of this section shall not be construed as limiting the Commissioner from making a finding that other factors not specifically enumerated in subsection (c) are necessary or desirable factors for the evaluation and maintenance of the sound financial condition and solvency of a health insurer.

Section 6 ***<u>Protecting the Interests of Consumers</u>***

(a) The interests of the consumers of health insurance, including individuals, groups and employers, must be protected.

(b) The provisions of this regulation do not require the Commissioner to act as an advocate on behalf of a particular health insurance consumer. Instead, while the Commissioner will endeavor to address individual consumer complaints as they arise, the OHIC Purposes Statute requires the OHIC to protect the interests of health insurance consumers, including individuals, groups and employers, on a system-wide basis.

(c) Whenever the Commissioner determines that

(i) the interests of the state's health insurance consumers are, or are likely to be, adversely affected by any policy, practice, action or inaction of a health insurer;

(ii) the approval or denial by the Commissioner of any regulatory request, application or filing made by a health insurer could adversely affect the interests of the state's health insurance consumers; or

(iii) any other circumstances exist such that the interests of the state's health insurance consumers may be adversely affected

the Commissioner shall, in addition to exercising any duty or power authorized or required by titles 27 or 42 of the General Laws related specifically to the protection of the interests of the consumers of health insurance, act to protect the interests of consumers of health insurance when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

(d) When making a determination as described in subsection (c) of this section or when acting to protect the interests of the state's health insurance consumers, the Commissioner may consider and/or act upon the following consumer interest issues, either singly or in combination of two or more:

(i) the privacy and security of consumer health information;

(ii) the efforts by a health insurer to ensure that consumers are able to

(A) to read and understand the terms and scope of the health insurance coverage documents issued or provided by the health insurer and

(B) make fully informed choices about the health insurance coverage provided by the health insurer;

(iii) the effectiveness of a health insurer's consumer appeal and complaint procedures;[1]

(iv) the efforts by a health insurer to ensure that consumers have ready access to claims information;

(v) the efforts by a health insurer to increase the effectiveness of its communications with its insureds, including, but not limited to, communications related to the insureds' financial responsibilities;

(vi) that the benefits in health insurance coverage documents issued or provided by a health insurer are consistent with state laws;

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[1] For matters other than medical necessity and utilization review, which are within the jurisdiction of the Department of Health.

(vii) that the benefits delivered by a health insurer are consistent with those guaranteed by the health insurance coverage documents issued or provided by the health insurer; and

(viii) the steps taken by a health insurer to enhance the affordability of its products, as described in section 9 of this regulation.

(e) The factors enumerated in subsection (d) of this section shall not be construed as limiting the Commissioner from making a finding that other consumer protection issues not specifically enumerated in subsection (d) are necessary or desirable factors upon which the Commissioner may act to protect the interests of consumers of health insurance.

Section 7 ***<u>Encouraging Fair Treatment of Health Care Providers</u>***

(a) The Commissioner will act to encourage the fair treatment of health care providers by health insurers.

(b) The provisions of this regulation do not require the Commissioner to act as an advocate for a particular health care provider or for a particular group of health care providers. Instead, while the Commissioner will endeavor to address individual health care provider complaints as they arise, the OHIC Purposes Statute requires the OHIC to act to enhance system-wide treatment of providers.

(c) Whenever the Commissioner determines that

(i) health care providers are being treated unfairly by a health insurer;

(ii) the policies or procedures of a health insurer place an undue, inconsistent or disproportionate burden upon a class or providers;

(iii) the approval or denial by the Commissioner of any regulatory request, application or filing made by a health insurer will result in unfair treatment of health care providers by a health insurer; or

(iv) any other circumstances exist such that Commissioner is concerned that health care providers will be treated unfairly by a health insurer

the Commissioner shall, in addition to exercising any duty or power authorized or required by titles 27 or 42 of the General Laws related specifically to the fair treatment of health care providers, take the treatment of health care providers by a health insurer into consideration when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

(d) When making a determination as described in subsection (c) of this section or when acting to encourage the fair treatment of providers, the Commissioner may consider and/or act upon the following issues, either singly or in combination of two or more:

(i) the policies, procedures and practices employed by health insurers with respect to provider reimbursement, claims processing, dispute resolution, and contracting processes;

(ii) a health insurer's provider rate schedules; and

(iii) the efforts undertaken by the health insurers to enhance communications with providers.

(e) The factors enumerated in subsection (d) of this regulation shall not be construed as limiting the Commissioner from making a finding that other factors related to the treatment of health care providers by a health insurer not specifically enumerated are necessary or desirable factors for the evaluation of whether health care providers are being treated fairly by a health insurer.[2]

Section 8 Improving the Efficiency and Quality of Health Care Delivery and Increasing Access to Health Care Services

(a) Consumers, providers, health insurers and the public generally have an interest in

(i) improving the quality and efficiency of health care service delivery and outcomes in Rhode Island;

(ii) viewing the health care system as a comprehensive entity; and

(iii) encouraging and directing insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

(b) The government, consumers, employers, providers and health insurers all have a role to play in increasing access to health care services and improving the quality and efficiency of health care service delivery and outcomes in Rhode Island. Nevertheless, the state's health insurers, because of their prominent role in the financing of health care services, bear a greater burden with respect to improving the quality and efficiency of health care service delivery and outcomes in Rhode Island, treating the health care system as a comprehensive entity, and advancing the welfare of the public through overall efficiency, improved health care quality, and appropriate access. Furthermore, a balance must be struck between competition among the health plans, which can result in benefits such as innovation, and collaboration, which can promote consumer benefits such as standardization and simplification.

(c) Whenever the Commissioner determines that

(i) the decision to approve or deny any regulatory request, application or filing made by a health insurer

(A) can be made in a manner that will

[2] The factors that may be considered by the Commissioner will not typically include those matters over which other agencies, such as the Department of Health, have jurisdiction.

(1) improve the quality and efficiency of health care service delivery and outcomes in Rhode Island;

(2) view the health care system as a comprehensive entity; or

(3) encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access; or

(B) should include conditions when feasible that will

(1) promote increased quality and efficiency of health care service delivery and outcomes in Rhode Island;

(2) incent health insurers to view the health care system as a comprehensive entity; or

(3) encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access; or

(ii) any other circumstances exist such that regulatory action by the Commissioner with respect to a health insurer will likely improve the efficiency and quality of health care delivery and increase access to health care services

the Commissioner shall, in addition to exercising any duty or power authorized or required by titles 27 or 42 of the General Laws related specifically to improving the efficiency and quality of health care delivery and increasing access to health care services, act to further the interests set out in subsection (a) of this section when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

(d) When making a determination as described in subsection (c) of this section or when acting to further the interests set out in subsection (a) of this section, the Commissioner may consider and/or act upon the following, either singly or in combination of two or more:

(i) Efforts by health insurers to develop benefit design and payment policies that:

(A) enhance the affordability of their products, as described in section 9 of this regulation;

(B) encourage more efficient use of the state's existing health care resources;

(C) promote appropriate and cost effective acquisition of new health care technology and expansion of the existing health care infrastructure;

(D) advance the development and use of high quality health care services (e.g., centers of excellence); and

(E) prioritize the use of limited resources.

(ii) Efforts by health insurers to promote the dissemination of information, increase consumer access to health care information, and encourage public policy dialog about increasing health care costs and solutions by:

(A) providing consumers timely and user-friendly access to health care information related to the quality and cost of providers and health care services so that consumers can make well informed-decisions;

(B) encouraging public understanding, participation and dialog with respect to the rising costs of health care services, technologies, and pharmaceuticals; the role played by health insurance as both a financing mechanism for health care and as a hedge against financial risk for the consumers of health care; and potential solutions to the problems inherent in the health insurance market (e.g., market concentration, increasing costs, the growing population of uninsureds, market-driven changes to insurance products (such as the growth of high deductible plans) and segmentation of the insurance market due to state and federal laws); and

(C) providing consumers timely and user friendly access to administrative information, including information related to benefits; eligibility; claim processing and payment; financial responsibility, including deductible, coinsurance and copayment information; and complaint and appeal procedures;

(iii) Efforts by health insurers to promote collaboration among the state's health insurers to promote standardization of administrative practices and policy priorities, including

(A) participation in administrative standardization activities to increase efficiency and simplify practices; and

(B) efforts to develop standardized measurement and provider payment processes to promote the goals set out in this regulation;

(iv) Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations and initiatives that promote quality, access and efficiency;

(v) Participating in the development and implementation of public policy issues related to health, including

(A) collaborating with state and local health planning officials;

(B) participating in the legislative and regulatory processes; and

(C) engaging the public in policy debates and discussions.

(e) The factors enumerated in subsection (d) of this section shall not be construed as limiting the Commissioner from making a finding that other factors may be considered when acting to further the interests set out in subsection (a) of this section.

Section 9 ***<u>Affordable Health Insurance</u>***

(a) Consumers of health insurance have an interest in stable, predictable, affordable rates for high quality, cost efficient health insurance products.

(b) The Commissioner will consider the following bases for assessing the affordability of health insurance products:

(i) Trends, including:

(A) Historical rates of trend for existing products;

(B) National medical and health insurance trends (including Medicare trends);

(C) Regional medical and health insurance trends; and

(D) Inflation indices, such as the Consumer Price Index and the medical care component of the Consumer Price Index;

(ii) Price comparison to other market rates for similar products (including consideration of rate differentials, if any, between not-for-profit and for-profit insurers in other markets);

(iii) The ability of lower-income individuals to pay for health insurance;

(iv) Efforts of the health insurer to maintain close control over its administrative costs; and

(v) Implementation of strategies by the health insurer to enhance the affordability of its products.

(c) A health insurer's strategies to enhance the affordability of its products will be evaluated based on the following:

(i) Whether the health insurer offers a spectrum of product choices to meet consumer needs;

(ii) Whether the health insurer offers products that address the underlying cost of health care by creating appropriate incentives for consumers, employers, providers and the insurer itself. Such incentives will drive efficiency in the following areas:

(A) Creating a focus on primary care, prevention and wellness;

(B) Establishing active management procedures for the chronically ill population;

(C) Encouraging use of the least cost, most appropriate settings;[3] and

(D) Promoting use of evidence based, quality care;

(iii) Whether the insurer employs provider payment strategies to enhance cost effective utilization of appropriate services;

(iv) Whether the insurer supports product offerings with simple and cost effective administrative processes for providers and consumers;

(v) Whether the insurer addresses consumer need for cost information through

(A) Increasing the availability of provider cost information; and

(B) Promoting public conversation on trade-offs and cost effects of medical choices; and

(vi) Whether the insurer allows for an appropriate contribution to surplus.

(d) The following constraints on affordability efforts will be considered:

(i) State and federal requirements (e.g., state mandates, federal laws);

(ii) Costs of medical services over which plans have limited control;

(iii) Health plan solvency requirements; and

(iv) The prevailing financing system in United States (i.e., the third-party payor system) and the resulting decrease in consumer price sensitivity.

Section 10 ***Severability***

If any section, term, or provision of this regulation is adjudged invalid for any reason, that judgment shall not affect, impair, or invalidate any remaining section, term, or provision, which shall remain in full force and effect.

Section 11 ***Construction***

(a) This regulation shall be liberally construed to give full effect to the purposes stated in R.I. Gen. Laws § 42-14.5-2.

(b) This regulation shall not be interpreted to limit the powers granted the Commissioner by other provisions of the law.

Section 12 ***Effective Date***

This Regulation shall be effective on the date indicated below.

EFFECTIVE DATE: _____, 2006

[3] This goal is meant to apply in the aggregate. Use of some higher cost providers and settings do result in better outcomes and should not be discouraged.