

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

CONCISE EXPLANATORY STATEMENT

**REGULATION 11
SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY REGULATION**

The Office of the Health Insurance Commissioner (“OHIC”) hereby adopts Regulation 11 as of January 7, 2008, with an effective date of January 28, 2008, and makes this statement in accordance with R.I. Gen. Laws § 42-35-2.3. This regulation is adopted to implement the provisions of Title 27, Chapter 50, the “Small Employer Health Insurance Availability Act” (the “Act”) and replaces Regulation 82 of the Department of Business Regulation (“DBR Regulation 82”), which had been adopted by OHIC. The purpose of the Act and this regulation is to provide for the availability of health insurance coverage to small employers and their employees and employees’ dependents, regardless of health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health benefit plans; to provide for uniform annual filing requirements by carriers participating in the small group health insurance market; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to direct the basis of market competition away from risk selection and toward the efficient management of health care; to provide for the availability of a wellness health benefit plan; to clarify the rules regarding the availability of individual health insurance policies to self employed-individuals and to improve the overall fairness and efficiency of the small group health insurance market.

The proposed regulation was publicly noticed on July 26, 2007 in the Providence Journal and a public hearing was held at 10 a.m. on Wednesday August 29, 2007 in the Main Hearing Room of the Department of Business Regulation building, 233 Richmond Street, Providence, Rhode Island.

The proposed regulation differed in certain respects from DBR Regulation 82. The following is a summary of those changes:

Three written comments were submitted before and during the public hearing. Changes were made to the proposed regulation as a result of the comments. Changes to the regulation, other than editing changes, are addressed below.

Objections to Section 3

The OHIC has declined to make a change to Section 3(d) based on an objection that the language of the section does not tie sufficiently to the statutory language. The Commissioner believes that the language is sufficient and almost a direct carryover from the regulation employed by the DBR.

Objections to Section 5

The OHIC agrees with comments suggesting changes to Section 5(d), except that the turn-around time for a document or information request shall remain at ten days, rather than ten business days. The Commissioner believes that ten days is a sufficient period to produce documents or information. Furthermore, should more time be needed by the carrier, the Commissioner has inserted the comment's suggested language that provides for an extension of time.

Objections to Section 6

One commenter has asked for confirmation that the provisions of this regulation replace DBR Notice 2002-5. This regulation replaces this Notice.

Objections to Section 10

The OHIC has declined to make a change to Section 10(b) related to the definition of offering and marketing health plans, except that the language "unless otherwise permitted or required by Rhode Island or federal law" Has been inserted to account for the requirements of any state or federal law that may place limits on the marketing of certain plans in the small employer market (i.e., the basic benefit health plan described in R.I.G.L. § 27-50-10.1). While the Commission agrees with the sentiments of the commenter on this issue, the Commissioner believes that the marketing and distribution problems in the small group market require a more comprehensive and focused approach in order to craft a workable solution.

Objections to Section 12

The OHIC has declined to make a changes to Section 12, except for changes to Section 12(f), that take into account information and documentation protected by R.I.G.L. § 27-50-5(h)(3). That provision states:

A small employer carrier shall make the information and documentation described in subdivision (1) of this subsection available to the director upon request. Except in cases of violations of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

The information and documentation described in subdivision (1) of subsection (h) expressly refers to "a complete and detailed description of *its rating practices and renewal underwriting practices*, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles." (emphasis added) This refers to a limited set of documents and information—related only to *rating practices* and *renewal underwriting practices*, and not to all information about the carrier's rates or trends in the small group market. Thus, Commissioner has added the reference to R.I.G.L. § 27-50-5(h)(3) in the regulation, but has not changed any other portions of this section.

One commenter has suggested that the information listed in Section 12(c) be changed and that consistent reporting requirements be developed in consultation with the carriers. While no

changes have been made to Section 12(c), the Commissioner agrees with the commenter and will contact the carriers to discuss this matter.

Other comments object to this section on the ground that the proposed changes to the small group rating process will “effectuate a drastic and profound change in the long-standing and well-functioning rating process in place in the small employer market.” One commenter argues that the proposed regulation will “transform the [rating] process from “an annual actuarial certification process of compliance to a file and approval process”—a process not used by any other state in New England. It is important to note that the annual certification process specified by R.I.G.L. § 27-50-5 does not preclude a requirement of additional filings by participants in the small employer market. Furthermore, R.I.G.L. §§ 27-19-6, 27-20-6 and 42-62-13 give the Commissioner express authority over rates proposed to be charged or a rating formula proposed to be used by any insurer or health maintenance organization for employers in Rhode Island.

The same commenter objects to the burden and costs of the annual filing and the potentially high cost of rate hearings for the small group market. The Commissioner does not believe that the annual filing requirements will be unduly burdensome or costly to the carriers. Such filings will certainly reduce the costs and burdens faced by the carriers during the triennial small employer market conduct exam. Also, carriers are already required to maintain the bulk of the information required for the annual filing. With respect to the hearings, the Commissioner is aware of the potentially high cost of rate hearings and does not expect that rate hearings will be commonplace in the small group market.

The same commenter suggests that the requirements related to actuaries are not supported by statute. The Commissioner takes the position that a requirement that an actuary submit portions of a filing implies that the Commissioner has the authority to determine whether the actuary’s credentials will be accepted.

Finally, the same commenter suggests that the term “medical loss ratio” be defined broadly. The term “medical loss ratio” is not defined in the regulation so that carriers have flexibility to use the term in the same manner as they have done in the past. Should this Office determine that additional guidance is necessary on this subject, the Office will issue such guidance in the form of a bulletin or an amendment to this regulation.

Objections to Section 14

Based on multiple comments from more than one commenter, the OHIC has made certain section-wide changes to Section 14 and to in order correct the incorrect *HEALTHpact* requirements for adolescent and child members.

The OHIC has declined to make a change to Section 14(d) related to how an individual in Basic can move to Advantage. The mechanics for such a transition will be left to the carriers.

Upon the request of a commenter, a change has been made to Section 14(d)(2)(D) to extend the date for the establishment of year three requirements to April of 2008.

Upon the request of a commenter, changes have been made to Section 14(d)(3) to reflect that a subscriber may submit a pledge form on behalf of family members.

Upon the request of a commenter, a change has been made to Section 14(e) to clarify that members will only move from one level of benefits to another on either the first day of the month following enrollment in the event the PHA is incomplete or the enrollment anniversary date. The OHIC has declined to make changes to Section 14(f), except for changes to Section 14(f)(6), which was changed to take into account the fact that all documentation will not be available online. The OHIC does not believe it necessary to distinguish between pre-enrollment from post-enrollment packages or clarify that required documents may be included in other materials. With respect to the standardized PHA issue, the Commissioner may or may not determine that a PHA should be standardized, thus no change is necessary.

Upon the request of a commenter, section 14(j)(2) has been changed to include a reference to Section 14(l).

The OHIC has declined to delete the style guide reference in Section 14(j)(4). The Commissioner believes that the style guide is useful for standardized branding purposes.

Upon the request of a commenter, Section 14(m)(1) has been changed to address a commenter's concern about timing constraints regarding the provision of information in enrollment of renewal packages.

Section 14(m)(4)(A) was changed to reflect the correct timing requirement. While not expressly stated, it is implicit that it is the responsibility of a member to obtain a physicians' signature.

The OHIC has declined to make changes to Section 14(m)(2) or (4) related to the use of a postmark date. While the Commissioner is sympathetic to the concerns of the commenter, the postmark date remains a standard practice and will therefore be used here.

Upon the request of a commenter, Section 14(n) was changed to take into account the concerns of the commenter related to discontinued plans. No change was made with respect to the issue of the continuing rate, but this regulation does not require a carrier to provide coverage at a discounted rate.

In order to address the concerns raised about the tiered network requirement, language was added to Section 14(o) to give the Commissioner flexibility to reexamine the existing requirements.

Upon the request of a commenter, Section 14(p) was changed to reflect the correct requirements.

Appendix C was changed to correct the incorrect *HEALTHpact* requirements for adolescent and child members.

Appendix F was deemed unnecessary and was deleted.