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### CONCISE EXPLANATORY STATEMENT

#### **Office of the Health Insurance Commissioner Regulation 15 – Discount Medical Plan Organizations**

The Office of Health Insurance Commissioner (“OHIC”) hereby adopts OHIC Regulation 15, effective June 1, 2011 and makes this statement in accordance with R.I. Gen. Laws § 42-35-2.3.

The Department adopts this rule in order to establish and implement a regulatory program for discount medical organization plans, in accordance with R.I. Gen. Laws Title 42, Chapter 74.

There are three differences between the text of the proposed rule as published in accordance with R.I. Gen. Laws § 42-35-3 and the rule as adopted, other than editing changes.

1. In response to a comment offered by the Consumer Health Alliance (“CHA”) dated March 15, 2011, Section 3(C) has been clarified to provide registrants the option of filing the required annual report with the renewal application during any year in which renewal is required.

2. In response to a comment offered by the CHA dated March 15, 2011, Section 4(C) has been amended to narrow the scope of criminal prosecutions of any principal or employee of the registrant. The final rule requires the reporting of any felony, and any misdemeanor alleging facts relating to the business of discount medical organization plans, the business of insurance, and any financial services business.

3. In response to a comment offered by the CHA dated March 15, 2011, Section 4(D) has been added to permit the electronic filing of reports required under Section 4.

4. The other comments offered by the CHA dated March 15, 2011 have not been accepted.

(a) CHA requested that the regulation delete the requirement that a change in any information provided in the application be reported to OHIC within 30 days. In not accepting this comment, OHIC observes that the Office’s ability to respond to consumer inquiries and complaints requires the prompt reporting of the important information included in the application. OHIC has amended this requirement by permitting the updated information to be filed electronically.

(b) CHA requested that OHIC’s consumer readability requirement be applicable only to those disclosures expressly stated in the statute. In not accepting this comment, OHIC observes that clear and understandable communications with consumers is a fundamental attribute of an effective market in financial services, such as the services offered by discount medical plan organizations. Furthermore, the statute does not limit OHIC from applying its readability standards to other consumer communications, and the authority granted to the Commissioner to adopt readability standards is very broad, including “advertisements, marketing materials, brochures, discount medical

plan cards, and any other communications by discount medical plan organizations to members and prospective members.

(c) CHA requested that the regulation permit a plan to describe the “range” of fees and charges paid by members in its application. In not accepting this comment, OHIC notes that a plan must disclose its charges to members, and that processing fees must be “reasonable.” R.I. Gen. Laws § 27-74-8(f), and R.I. Gen. Laws § 27-74-8(a). Effective enforcement of these requirements would be compromised in the absence of information provided by the plan concerning member fees and charges. In a similar comment, CHA requests that lists of participating providers not be included in the application. In not accepting this comment, OHIC notes that effective enforcement of statutory and regulatory requirements relating to provider lists would be compromised in the absence of such information being affirmatively included in the application by the registrant.

Dated at Cranston, Rhode Island this 25<sup>TH</sup> day of April, 2011.

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Christopher Koller, Commissioner  
Office of the Health Insurance Commissioner