

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
233 RICHMOND STREET
PROVIDENCE, RHODE ISLAND 02903**

FINAL ORDER (OHIC-2007-5)

Wellness Health Benefit Plan Submission by Blue Cross & Blue Shield of Rhode Island

THIS MATTER comes before the Health Insurance Commissioner (the “Commissioner”) as a result of a submission by Blue Cross & Blue Shield of Rhode Island (BCBSRI) of certain Design Documents related to the wellness health benefit plan (WHBP) established by R.I.G.L. § 27-50-10. BCBSRI’s Design Documents incorporate the requirements of the R.I.G.L. § 27-50-1 *et seq.*, the recommendations of the advisory committee established by the General Assembly to provide guidance to the OHIC with respect to the development of the WHBP (the Committee), the WHBP Products Requirements Document (the Requirements Document), guidance from the Office of the Health Insurance Commissioner (OHIC), and the elements of OHIC Bulletin 2007-1. The Commissioner has reviewed and considered BCBSRI’s Design Documents. After full review and consideration of Design Documents, relevant statutes and regulatory guidance, and input from the Committee, the Commissioner issues the following Order:

1. BCBSRI’s Design Documents conform substantially to the requirements set out in R.I.G.L. §§ 27-50-5(h)(4) and 27-50-10, the Requirements Documents, and regulatory guidance from OHIC and are therefore approved, conditioned on minor modifications to BCBSRI’s Design Documents;
2. The minor modifications to plan design include:
 - a. An increase in the Basic plan calendar year deductible;
 - b. A decrease of annual out-of-pocket maximums for the Advantage plan;
 - c. A decrease of the primary care physician office visit copay for the Advantage plan;

- d. A decrease of the urgent care facility and outpatient facility copay for the Advantage and Basic plans;
 - e. An increase in the emergency room and urgent care services physician office visit copay for the Advantage plan;
 - f. An increase in the Advantage plan coinsurance for diagnostic imaging and machine tests; and
 - g. A decrease in the Advantage plan calendar year pharmacy deductibles;
3. The average annualized premium shall be \$322.00;
 4. The WHBP will be offered both on a dual option and sole replacement basis to all small group employers;
 5. BCBSRI may set an initial enrollment cap of no fewer than 5,000 members;
 6. BCBSRI's WHBP plan shall be available on or before October 1, 2007 in accordance with the terms and conditions of this Order and any other subsequent guidance provided by OHIC; and
 7. BCBSRI shall actively market the WHBP. Active marketing includes, but is not limited to, developing and conducting an ongoing marketing campaign to raise awareness and educate the marketplace about the availability of the WHBP.

The details of these elements, as well as other requirements of the Order, are discussed in further detail below.

INTRODUCTION AND REVIEW OF THE PLAN DEVELOPMENT PROCESS

The development of the WHBP was the result of efforts by the General Assembly, the OHIC, the Committee and the state's two major health insurers to create an affordable health insurance product for low-wage small businesses.

Statutory Background

In July of 2006, the General Assembly enacted "The Rhode Island Health Care Affordability Act of 2006 – Part I An Act Relating to Small Group and Individual Health Insurance" (the Act).¹ The Act amended several provisions of the General Laws in Chapter 27-50, entitled "Small Employer Health Insurance Availability Act." The amendments repealed

¹ P.L. 2006, ch. 258, §1; P.L. 2006, ch. 296, §1 (P.L. 2006, ch. 258 and P.L. 2006, ch. 296 enacted identical versions of the Act.

provisions requiring participants in Rhode Island’s small employer health insurance market to offer so-called “Standard” and “Economy” plans and created a new mandatory product to be offered in the small group market: the wellness health benefit plan (WHBP).²

The General Assembly charged the OHIC with creating the criteria for the WHBP, including, but not limited to, benefit levels, cost-sharing levels, exclusions, and limitations, in accordance with recommendations from the Committee, which would be comprised of representatives of employers, health insurance brokers, local chambers of commerce, and consumers who pay directly for individual health insurance coverage.

Among other things, the General Assembly required the Committee to develop a health insurance plan that:

1. Established a target for the average annualized individual premium rate that would be less than ten percent of the “average annual statewide wage” (AASW). The AASW is the wage reported by the Rhode Island Department of Labor and Training in their report entitled “Quarterly Census of Rhode Island Employment and Wages.”³
2. Ensured that the plan created appropriate incentives for employers, providers, health plans and consumers to, among other things:
 - a. Focus on primary care, prevention and wellness;
 - b. Actively manage the chronically ill population;
 - c. Use the least cost, most appropriate setting; and
 - d. Use evidence based, quality care.⁴

² See R.I.G.L. § 27-50-10.

³ The statute also provides that:

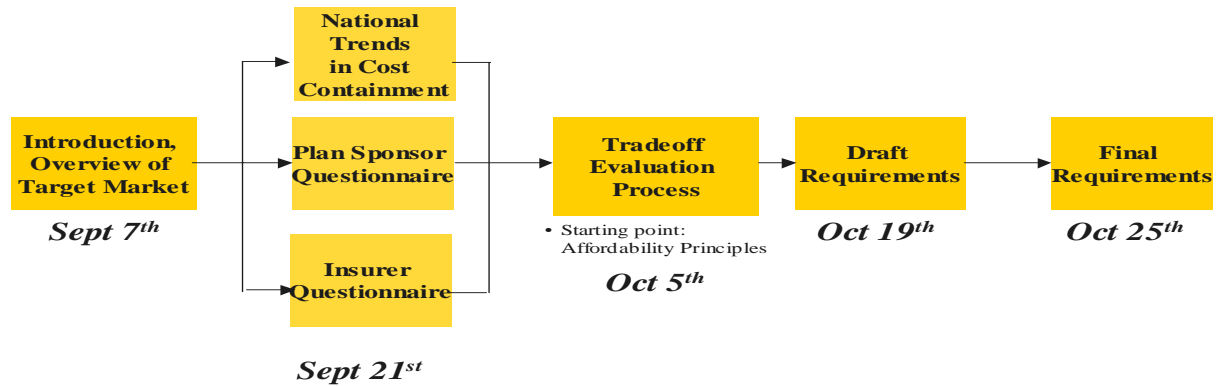
In the event that this report is no longer available, or the OHIC determines that it is no longer appropriate for the determination of maximum annualized premium, an alternative method shall be adopted in regulation by the OHIC. The maximum annualized individual premium rate shall be determined no later than August 1st of each year, to be applied to the subsequent calendar year premium rates.

R.I.G.L. § 27-50-10(b)(2).

⁴ R.I.G.L. § 27-50-10(b)(3).

The Committee

The Committee was convened by the OHIC in August of 2006 and began to meet according to a bi-weekly schedule between September 7, 2006 and October 25, 2006. The meetings were facilitated by Boston Benefit Partners and OHIC staff, and followed a specified process as shown below:



The process extended beyond the original schedule and an additional meeting was added on November 9, 2006. The purpose of the meetings was to develop standardized criteria for the WHBP and to produce guidance to health insurers, in the form of the Wellness Health Benefit Plan Products Requirements, so that the insurers could develop a WHBP product. The Requirements Document was issued on November 15, 2006.⁵

The Requirements Document

The final Requirements Document, which incorporated the legislative requirements for the WHBP, was submitted to BCBSRI and UnitedHealthcare of New England Inc., the state's two major insurers in the small employer market, by Boston Benefit Partners, on behalf of OHIC

⁵ R.I.G.L. § 27-50-10(b)(1)(ii)(A) sets a deadline of November 1, 2006 for the Requirements Document. Because the contents of the Requirements Document were substantially complete by November 1, 2006, the health insurers were kept informed with respect to the development of the Requirements Document, and an abrupt shift to a regulation-based development of the WHBP plan would result in further delays, the Commissioner determined that the WHBP development process should proceed using the Requirements Document.

and the Committee, on November 15th, 2006. The Requirements Document is attached hereto as Exhibit 1. The criteria for the WHBP as established by the Requirements Document (with subsequent clarifications by OHIC) includes the following:

1. Average Annualized Premium Rate

The WHBP legislation set a target for the average annualized individual premium rate to be less than ten percent of the average annual statewide wage, as set out in the Department of Labor and Training's quarterly wages report. Based on this report, OHIC has determined that the target average annualized premium rate for 2007 is \$314 and for 2008 is estimated at \$323.⁶

2. Implementation of WHBP

The legislation specifies that the product shall be made available on or before May 1, 2007. However, given the delays in the development process to date, plus the complexity of the new product proposals put forth, the implementation date has been extended to October 1, 2007.⁷

3. Plan Design—Wellness Features

The Wellness Health Benefit Plan (WHBP) contains a unique, two-tiered plan design that promotes primary care, prevention and wellness. The top tier is the "Advantage" plan, which

⁶ This annual rate does not include a quarterly trend factor. Instead, all new/renewal accounts in a given calendar year will be given the same "base rate". For example, an account that signs on in October will be quoted the same base rate as an account that signs on in March. In addition, all accounts for the WHBP will be moved to a January annual renewal cycle. So, for example, if an account signs up in October, their rates will increase, along with all WHBP accounts, on January 1 and will remain at that rate until January 1 of the following year. This is a departure from the norm in the small group market, but is in practice in other markets and was necessary to conform to the law.

⁷ This later date is complicated by the uniform January annual renewal cycle. As such, the Wellness Health Benefit Plan will be offered to all small employers beginning on October 1, 2007, with a fifteen-month rate. OHIC has therefore developed an adjusted target rate based on a 15 month "average premium target rate" of \$322 for the 15-month period beginning October 1, 2007 and ending December 31, 2008. This \$322 target was arrived at by taking the 2007 \$314 target rate and adjusting it to be consistent with the estimated AASW in mid-2008. Small group rates (and plan design features) will not be changed again until January 1, 2009 in accordance with the January annual renewal cycle.

affords its members lower copays, deductibles and out of pocket costs. The lower tier is the “Basic” plan, which has higher deductibles and out of pocket costs.

For a participant to be eligible for the Advantage plan design, the participant must comply with specified wellness requirements. These requirements include:

- Selection of a Primary Care Physician (PCP);
- Completion of a Health Risk Appraisal (HRA);
- Participation in Smoking Cessation Programs;
- Participation in Weight loss/Weight Management Programs; and
- Participation in Disease Management and/or High Cost Case Management Programs, when identified by the insurer.

Advantage participants will pay less for medical care, as follows:

- Lower copays for physician visits;
- Lower coinsurance for specific procedures;
- Lower annual deductibles; and
- Lower out-of-pocket maximums.

Participants who do not complete these items will be enrolled in the Basic plan and will be subject to higher deductibles and out of pocket costs.

4. Plan Design—Subsequent Year Participation

One of the unique features of the WHBP is that its compliance features become more significant over time. In the first year, Advantage-level benefits are tied to selection of a PCP, completion of an HRA, and a “Pledge”, or commitment to participate in smoking cessation, weight loss/weight management programs, and disease management programs if identified. In year two, the Advantage plan discount is linked to both a pledge and actual adherence to a program. For example, a smoker must pledge to begin a smoking cessation program in the first year and must follow through with that pledge. In the second year, the Advantage plan participant must demonstrate prior adherence to such a program and must pledge to continue to

participate.⁸ The specific Wellness Requirements, in year 1 and year 2, are attached to this Order as Exhibit 2.⁹

5. Plan Design—Miscellaneous

A few additional key points have been clarified with regard to the Wellness Compliance Standards for this product:

- The same rules would apply for children as apply to adults. All family members must meet the Wellness requirements to be eligible for the Wellness Advantage level of benefits.
- Determination of Advantage versus Basic eligibility will be made by the insurers, based on guidelines to be issued by this Office, developed jointly with the insurers. These guidelines will provide for an appropriate appeals process of determinations. Members will only move from one plan to another (e.g., Advantage to Basic) on the plan anniversary date.¹⁰
- The Committee recommends that insurers provide ongoing coaches to those identified as “at risk” for chronic illness to assist members in achieving improved health status. This could be a new, existing or modified function performed or contracted by the plan.

The Design Documents

Insurers were initially given until January 2nd, 2007 to submit formal, written responses to the Requirements Document. A question and answer session was held between OHIC and the insurers on November 28, 2006. Formal OHIC responses were then submitted to the insurers on December 11, 2006. Given the delay in the product requirements submission, the complexity of

⁸ There will be additional requirements to maintain Advantage-level benefits in the third year. Those requirements shall be determined by OHIC by regulation on or before September 1, 2008.

⁹ It will be the responsibility of the participant to provide the necessary documentation to prove eligibility for Advantage level benefits. As part of this documentation, participants may be required to provide a completed “PCP checklist”, with status evaluation and recommendations for improvement from the participant’s physician. In this checklist, the PCP may attest to participation in weight loss and smoking cessation programs. The participant would be responsible for obtaining the completed PCP checklist and including it as part of their enrollment/renewal process. The PCP checklist will be provided to employees as part of the WHBP underwriting/enrollment process. The health plans, with input from OHIC, shall develop this PCP checklist on or before September 1, 2007.

¹⁰ This Office recognizes that much work beyond this Order will be required by both insurers and the Office to interpret and comply with the Design elements specified in this product. As a general principle, interpretations will be reached in consultation with all parties, will be consistent among insurers and will be documented appropriately.

the issues raised in the Q&A session, and the challenges of holiday scheduling, the insurer deadline for submission was extended until January 12, 2007.¹¹

Insurer proposals were received by OHIC, as requested, on January 12, 2007. These proposals were reviewed with the Committee on February 1, 2007. Based on the feedback of the Committee and OHIC, the insurers then resubmitted “best and final” proposals to OHIC on March 12, 2007. BCBSRI’s Design Documents are attached hereto as Exhibit 3.

Review of the Design Documents

These “best and final” proposals were reviewed with the Committee on March 15, 2007. At this meeting, the Committee offered the following key points of feedback on the “best and final” proposals:

- The Committee members praised efforts by OHIC and the insurers to develop a “compromise plan design” and voiced appreciation for the challenge and the results.
- The Committee expressed significant concern regarding the marketability of the Advantage plan design given the high cost sharing. The committee noted that relatively little actuarial value was given to the five wellness components identified in requirements document. Specifically, the Committee voiced concern regarding high out-of-pocket maximums and the separate prescription deductibles. The Committee suggested that they were willing to consider increases in cost sharing for the Basic plan

¹¹ The direct pay timeline has also been extended. Once the Small group product regulations have been finalized, and the product effective date has been reached, attention will shift to Direct Pay. Timing of Direct Pay implementation is currently complicated by three key factors:

1. There are a variety of bills in the legislature this session relating to a small group/direct pay merger. Such a merger would significantly impact when/how to introduce WHBP to the direct pay market.
2. An additional insurer, Golden Rule, has recently submitted an application to participate in the Direct Pay market. Adding competition to this market will substantially change the existing market offerings, and could significantly impact the WHBP offering to direct pay members.
3. The Wellness elements of the plan design, with the advantage/basic structure, may need to be adapted, to create appropriate incentives in a direct pay market.

Based on these three considerations, we anticipate that the WHBP product for the direct pay market will be made available to direct pay members by approximately January 1, 2009. In addition, the Product Requirements document submitted to the insurers on November 15th, 2006 also included a request for plan design options for a product targeting the uninsured, to be offered in the direct pay market. This was not explicitly required by legislation, but was requested by the committee. Neither insurer responded to this request. This requirement has been postponed indefinitely, awaiting the results of a variety of legislative proposals under consideration during the 2007 session.

if such increased cost sharing could be used to offset cost sharing decreases on the Advantage side.

- The Committee expressed significant concern that the WHBP might be offered on a sole replacement basis only. While insurers maintained that the WHBP must include all enrollees from an offering business (sole replacement), most Committee members argued that dual option was not financially damaging to the insurers and was a critical success factor for this product.
- The Committee discussed, without conclusion, concerns about the fifteen-month time horizon, and the January renewal cycle. Many recognized the implementation challenges of such an approach.

Acceptance of the Design Documents with Modifications/Other Conditions

In response to the insurers' "best and final" submissions, the Committee's review of and comments on those submissions, and the Commissioner's review and consideration of those submissions, the Commissioner determined that, pursuant to the requirements of relevant statutes, regulatory guidance provided to the insurers, and in accordance with the standards and guidelines set out in OHIC Bulletin 2007-1, the submissions by both insurers conform substantially to the requirements set out in R.I. Gen. Laws §§ 27-50-5(h)(4) and 27-50-10, the Requirements Documents and regulatory guidance from OHIC. Based on this determination, the Commissioner approved, conditioned on minor modifications, the insurers' submissions.

1. Modification to BCBSRI Plan Design

Certain elements of BCBSRI's WHBP configuration were modified, as requested by the Committee in the March 15th, 2007 review meeting. The modifications made to BCBSRI's Design Documents include:

- An increase in the Basic plan calendar year deductible;
- A decrease of annual out-of-pocket maximums for the Advantage plan;
- A decrease of the primary care physician office visit copay for the Advantage plan;
- A decrease of the urgent care facility and outpatient facility copay for the Advantage and Basic plans;
- An increase in the emergency room and urgent care services physician office visit copay for the Advantage plan;

- An increase in the Advantage plan coinsurance for diagnostic imaging and machine tests;¹² and
- A decrease in the Advantage plan calendar year pharmacy deductibles.

Based on analyses by OHIC's consulting actuary, the offsetting nature of these changes are expected to result in no net change in the cost of the plan as set out in the January 12, 2007 submission.

In addition, two other modifications were made:

- The submission was updated to include details that were not included in the March 12, 2007 submission. Those details were updated to fill out the plan design document and were made in way to be consistent with final submissions of the detailed plan design.
- The average annualized premium is \$322.00.

BCBSRI's WHBP final configuration is attached as Exhibit 4.

2. Network commitment and timeline

The Requirements Document called for a benefit design to be implemented over a specified time frame that differentiated benefits for different providers based on insurer assessment of quality and efficiency. A Tiered Network summary, comparing "best and final" insurer proposals (submitted on March 12, 2007) to final approved network commitments under this order is provided in Exhibit 5. The final approved network commitment included the following modifications, as requested by the Committee in the March 15th, 2007 review meeting:

- Insurers are allowed flexibility to develop their own form of network tiers, in accordance with the Affordability Principles outlined in the legislation.
- Each insurer's tiered network structure must be implemented for all new/renewal WHBP members no later than January 1, 2009. OHIC rating decisions for 2009 will assume compliance with this requirement.
- Draft tiered network proposals to be implemented on January 1, 2009 must be submitted to OHIC on or before September 1, 2007.

¹² If, however, insurers wish to reduce the coinsurance level below the 90%, they may only do so for tier 2 providers. (See discussion of Network Tiering, below)

- Based on the feedback of OHIC and the Committee, final tiered network proposals to be implemented on January 1, 2009 must be submitted to OHIC on or before January 1, 2008. OHIC decisions regarding insurer proposals will be determined on or before February 1, 2008.
- OHIC decisions regarding future revisions/phased implementation of network proposals (after 1/1/2009) will be made in response to the final proposals submitted above.

3. Marketing commitment

The insurers shall actively market the WHBP. Active marketing includes, but is not limited to, the following:

- As part of the insurer's overall company marketing plan, developing and conducting an ongoing marketing campaign to raise awareness and educate the marketplace about the availability of the WHBP; and
- Conduct promotional and advertising campaigns (a) through print, radio, and other media; and (b) through written and electronic communications sent to insurer's members, employers, participating providers and brokers, such as newsletters, brochures, and on insurer's websites.

Insurers shall submit product marketing plans to OHIC for prior review. Draft marketing plans must be submitted by insurers to OHIC on or before April 13, 2007. Insurers must then meet with representatives from OHIC on or before April 20, 2007 to review and discuss these draft plans. Insurers shall then submit final marketing plans to OHIC on or before April 27, 2007. OHIC will approve, reject or modify these plans on or before May 4, 2007. The proposed WHBP marketing plans submitted by the insurers must include, at minimum, the elements provided in Exhibit 6.

4. Dual Option

The WHBP must be offered both on a dual option and sole replacement basis to all small group employers.¹³ The Committee, in the March 15, 2006 meeting, provided feedback to OHIC and the insurers that this was a critical element of the product's market appeal in its first year.

This requirement will be revisited annually, with the first evaluation performed in time to affect the January 1, 2009 offering. At that time, the dual option requirement will be evaluated in terms of its impact on each insurer's WHBP membership, loss ratio, and other relevant metrics.

5. Enrollment Cap

This is a unique new product, with innovative plan design elements, many of which are difficult to assess from an actuarial basis. As such, each insurer may set an enrollment cap of no fewer than 5,000 members. If and when the cap is reached, insurers may cease to offer the product to its brokers. This decision is within the jurisdiction of the Commissioner and will be revisited annually after review with the insurers, with the first evaluation performed in time to affect the January 1, 2009 offering.

6. Branding/Product name

An official name for the WHBP, as well as a decision on how to co-brand or tag-line the product, will be defined in regulations to be issued by OHIC.

¹³ "Offered" means that every rate sheet from the insurer to a broker or a small group must include the WHBP as an option.

FINDINGS OF FACT

1. The preceding sections of this Order and all Exhibits appended to this Order are incorporated into these Findings of Fact.
2. BCBSRI is a Rhode Island nonprofit hospital and medical service corporation.
3. In accordance with R.I.G.L. § 27-50-10, the OHIC convened the Committee and developed the requirements for the WHBP.
4. The requirements for the WHBP were disseminated to BCBSRI in a Requirements Document for development of a BCBSRI-specific WHBP.
5. BCBSRI was required to respond to the OHIC and the Committee with a Design Document that represented BCBSRI's efforts to develop its WHBP with the cost and benefits parameters established by the Requirements Documents.
6. BCBSRI timely submitted its Design Document to OHIC.
7. BCBSRI's Design Document was reviewed by the Committee. The Committee, while appreciative of the efforts of BCBSRI and UnitedHealthcare of New England, Inc., had concerns about certain aspects of the Design Documents submitted by both insurers.
8. After a review of BCBSRI's Design Documents, the Commissioner determined that BCBSRI's Design Documents conform substantially to the requirements set out in R.I. Gen. Laws §§ 27-50-5(h)(4) and 27-50-10, the Requirements Documents and regulatory guidance from OHIC and are therefore approved, conditioned on minor modifications to BCBSRI's Design Documents.
9. However, the Commissioner made adjustments to BCBSRI's Design Documents in accordance with the concerns of the Committee.

10. In addition, other conditions and specifications were made related to, among other things, network, branding, dual option requirements, the commencement date and enrollment caps.
11. Any Conclusion of Law that is also a Finding of Fact is hereby adopted as a Finding of Fact.

CONCLUSIONS OF LAW AND ORDER

1. The preceding sections of this Order, including the Findings of Fact and all Exhibits appended to this Order, are incorporated into these Conclusions of Law.
2. The OHIC has jurisdiction in this matter pursuant to R.I.G.L. §§ 42-14.5-1 *et seq.*, 42-14-5(d) and 27-50-1 *et seq.*
3. The process employed to convene the Committee, develop the Requirements Document, solicit Design Documents from the insurers and render a decision on those submissions was conducted in accordance with the provisions of R.I.G.L. §§ 27-50-1 *et seq.* and all other applicable provisions of titles 27 and 42 of the General Laws.
4. As a matter of law, the Commissioner determined that BCBSRI's final Design Documents, while conforming substantially to the requirements set out in R.I. Gen. Laws §§ 27-50-5(h)(4) and 27-50-10, the Requirements Documents and regulatory guidance from OHIC, could be approved only with minor modifications to BCBSRI's Design Documents.
5. The modifications, detailed extensively throughout this Order and its Exhibits, were properly made in accordance with applicable statutes, guidance from the Committee, and appropriate regulatory oversight.
6. Accordingly, the Design Documents submitted by BCBSRI are accepted with the aforementioned modifications.

7. Any Finding of Fact that is also a Conclusion of Law is hereby adopted as a Conclusion of Law.

WHEREFORE: It is hereby ordered that the above Order is approved this 2nd day of April, 2007.



Christopher F. Koller
Health Insurance Commissioner