Rhode Island

APPLICATION COVER SHEET AND CHECK-OFF LIST

Identifying Information

Grant Opportunity: **HHS Health Insurance Rate Review Grants – Cycle I**

DUNS #: 929956092 Grant Award: $1 million

Applicant: State of Rhode Island

Primary Contact Person, Name: Christopher F Koller

Telephone Number: (401) 462 – 9638 Fax Number: (401) 462 – 9645

Email address: ckoller@ohic.ri.gov

RHODE ISLAND

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below. Please ensure that the project narrative is page-numbered. The sequence is:

X	Cover Sheet
X	Forms/Mandatory Documents (Grants.gov)
	The following forms must be completed with an original signature and enclosed as part of the proposal:
X	SF-424: Application for Federal Assistance
X	SF-424A: Budget Information
X	SF-424B: Assurances-Non-Construction Programs
X	SF-LLL: Disclosure of Lobbying Activities
X	Additional Assurance Certifications
X	Required Letter of support and Memorandum of Agreement
X	Applicant's Application Cover Letter
X	Project Abstract
X	Project Narrative
X	Work Plan and Time Line
X	Proposed Budget (Narrative/Justifications)
X	Required Appendices
X	Resume/Job Description for Project Director and Assistance Director

Premium Review Grant Activity Timeline

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Expand the Scope of Current Rate Review and approval activities in Rhode Island	Work with affordability consultant to monitor health insurers' compliance with affordability standards, oversee utilization and hospital payment evaluations, and engage in ad hoc analyses of underlying cost drivers.			
	Hospital Utilization Evaluation: complete interim evaluation of cost and utilization measures prior to completion of an all-payer database in 2011.			
	Hospital payment evaluation: evaluate hospital payments for inpatient and outpatient care by payer type and compare to costs to document any cross-subsidization			
	Work with actuary to reconcile past rate review submissions by health insurer with the past actual financial performance			
	Contract with analyst to study cost drivers, financial data, enrollment trends, interstate comparisons, and benchmarks			
Enhance the rate review process through staffing	Hire one FTE dedicate to managing the rate review process			
	Work with actuary to develop database of rate filing information			
	Work with NAIC to assist in developing and implementing revised SERFF modules to capture and report additional information related to rate filings			
	File required information on rate filingswith HHS			
	Work with consultant to align current state rate review process with anticipated federal changes			
Enhance the rate review process through staffing	Contract with community organization to assist OHIC in engaging consumers in the rate review process			
		Contract with web designer to assist OHIC in improving public awareness and accessibility of rate filing submissions and decisions		
		Work with communication consultant to communicate results of evaluations conducted through this grant to health plans, hospitals, providers, regulators, and other interested stakeholders		

State of Rhode Island and Providence Plantations
State House
Providence, Rhode Island 02903-1196
401-222-2080

Donald L. Carcieri
Governor

July 5, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Sebelius:

This letter is in support of the application of the Office of the Health Insurance Commissioner of the State of Rhode Island for federal funds available to enhance the state's commercial health insurance rate review process.

Under the leadership of our Health Insurance Commissioner, Christopher Koller, Rhode Island has been a leader in health insurance rate review:

- In Rhode Island, proposed rates for individual, large and small group markets are reviewed annually in a public and transparent manner.
- The Commissioner must balance solvency and affordability concerns in making rate decisions.
- As a result, health insurance premiums are rising at more moderate and predictable levels than in some other states, but they are still too high.
- Health insurers in Rhode Island are directed towards policies that intend to change the delivery system -- including promoting primary care, Health Information Technology and comprehensive provider payment reform.

We look forward to using these grant funds to accomplish the two stated project goals:

- *Thorough evaluation of proposed health insurance rate increases and, to the extent permitted by law, (dis)approval through a comprehensive rate review process that is meaningful and transparent to all stakeholders.*

- *Infrastructure development to collect, analyze, and report to the Secretary critical information about rate filings and the review and, to the extent permitted by law, the approval and disapproval process.*

Our proposal builds on our nationally recognized work by increasing our analytical capacities to allow for more comprehensive review, monitoring the work of health insurers in improving insurance affordability, doing specific studies to document the need for comprehensive payment reform to promote insurance affordability, and increasing consumer engagement in the rate review process. We verify that the grant funds used to enhance rate review will not supplant any existing state expenditures.

We believe this work is necessary to help build a medical care system in Rhode Island that is more efficient and results in better patient experiences of care and improved overall health.

Thank you for your consideration. Please contact Commissioner Koller with any questions.

Sincerely,

Donald L. Carcieri
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Budget Narrative

Rhode Island's share of funds expended for rate review activities under the state's proposed plan for rate review will not be less than the state share of funds expended in Fiscal Year 2010. The Office of the Health Insurance Commissioner assures that the grant funds will only be used to enhance the Rhode Island's existing state rate review efforts, not as a substitute for existing funding for rate review efforts. As such, this grant will not fund any part of the salaries of the Health Insurance Commissioner, the Executive Counsel, or the Office Coordinator, even though each will continue to have a role in the rate factor review and will oversee projects outlined in this grant.

a. Personnel **$80,000**

This includes salary for one full-time staff member dedicated to managing the rate review process.

b. Fringe Benefits **$29,600**

Fringe benefit rate for the state is 37%. This rate was previously calculated and approved for federal grants to Rhode Island Department of Human Services from US Department of Health and Human Services.

c. Travel **$3,800**

Out-of-state Travel $3,000

Opportunities to work with state and/or federal officials to share rate review process

Local Travel $800

Mileage for project staff to travel in-state and regionally to support project activities, as required. Reimbursed at the rate of $0.55 per mile; estimated at approximately 120 miles per month.

d. Equipment **$4,500**

Equipment includes a computer, phone, fax/printer, office equipment, and other necessities for newly hired full-time staff.

e. Supplies **$5,000**

General office supplies used by the project staff including files, pens/pencils, paper, computer supplies, etc. necessary to conduct the day-to-day operations of the project. Supplies are estimated at 6.25 percent of grant-funded salaries.

f. Contractual **$855,000**

Eight (8) new subcontracts to conduct and support project activities are planned for the grant period. They are described as follows:

1. ***Actuary*** ***$30,000***
   Purpose: Develop data bank of rate filing information
   Cost estimate: 62.5 hours at $400 per hour + 20% overhead
2. ***Affordability Consultant*** ***$120,000***
   Purpose: Monitor health insurers' compliance with affordability standards, oversee utilization and hospital payment evaluations, and engage in ad hoc analyses of underlying cost drivers.

Cost estimate: 667 hours at $150 per hour + 20% overhead

3. ***Hospital Utilization Evaluation*** ***$100,000***
   Purpose: Complete interim evaluation of cost and utilization measures prior to completion of an all-payer database in 2011.
   Cost estimate: Estimated by Rhode Island Department of Health
4. ***Hospital Payment Evaluation*** ***$225,000***
   Purpose: Evaluate hospital payments for inpatient and outpatient care by payer type and compare to costs to document any cross-subsidization.
   Cost estimate: Estimated by consultant who performed preliminary work
5. ***Consumer Organization*** ***$125,000***
   Purpose: Assist OHIC in engaging consumers in the rate review process
   Cost estimate: Estimated as one FTE + fringe + communications and administrative support for a community organization
6. ***Web Design Consultant*** ***$30,000***
   Purpose: Assist OHIC in improving public awareness and accessibility of rate filing submissions and decisions.
   Cost estimate: Estimated market rates: 250 hours at $100 per hour + 20% overhead
7. ***Communication Consultant*** ***$30,000***
   Purpose: Communicate results of evaluations conducted through this grant to health plans, hospitals, providers, regulators, and other interested stakeholders.
   Cost estimate: 167 hours at $150 per hour + 20% overhead
8. ***Aligning State Rate Review Process with Federal Requirements*** ***$45,000***
   Purpose: Develop plan to align current state rate review process with anticipated changes outlined in the Affordable Care Act.
   Cost estimate: 250 hours at $150 per hour + 20% overhead
9. ***Reconciliation Project*** ***$30,000***
   Purpose: Reconcile past rate review submissions by health insurers with the past actual financial performance.
   Cost estimate: 62.5 hours at $400 per hour + 20% overhead
10. ***Cost Driver Analyst*** ***$120,000***
    Purpose: Contract with analyst to study cost drivers, financial data, enrollment trends, interstate comparisons, and benchmarks.
    Cost estimate: 667 hours at $150 per hour + 20% overhead

g. Construction **$0**

h. Other **$22,100**

1. Funding direct to National Association of Insurance Commissioners to automate some functions of the System for Electronic Rate and Form Filing. $18,000
2. Funding allocated for grant auditing (0.41% of total) $4,100

j. Indirect Costs **$0**

k. Totals **$1,000,000**

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j. Indirect Costs **$0**

k. Totals **$1,000,000**

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Premium Review Grant

*** Year:** 1

*** Funding Agency Goal:**

Increases in health insurance premiums and rate filings are thoroughly evaluated and, to the extent permitted by law, approved or disapproved through a comprehensive rate review p

*** Objective:**

Improve consumer protection standards and communications in the rate review process

*** Results or Benefits Expected:**

Increased transparency and consumer engagement in the rate review process.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Contract with community organization to assist OHIC in engaging consumers in the rate review process.	Executive Counsel	08/09/2010	09/30/2011	1,500
Contract with web designer to assist OHIC in improving public awareness and accessibility of rate filing submissions and decisions.	Executive Counsel	01/01/2011	09/30/2011	250
Work with communication consultant to communicate results of evaluations conducted through this grant to health plans, hospitals, providers, regulators, and other interested stakeholders.	Executive Counsel	01/01/2011	09/30/2011	167

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

Greater public awareness of and support for rate review work of OHIC. Greater public awareness of systemic cost drivers and support for affordability standards, and of increased receipt of public comment during rate review. Enhanced web functionality with increased traffic to OHIC's website. Communication of evaluation results to stakeholders.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Premium Review Grant

*** Year:** 1

*** Funding Agency Goal:**

States develop the infrastructure to collect, analyze, and report to the Secretary critical information about rate filings and the review and, to the extent permitted by law, the

*** Objective:**

Enhance the rate review process through staffing

*** Results or Benefits Expected:**

Expanded capacity to review rates and report to the Secretary rating filing and review information.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Hire one full-time staff member dedicated to managing the rate review process	Health Insurance Commissioner	08/09/2010	09/30/2011	0
Work with consulting actuary to develop database of rate filing information	Rate Review Manager	09/01/2010	12/31/2010	63
Work with NAIC to assist in developing and implementing revised SERFF modules to capture and report additional information related to Rate Filings.	Rate Review Manager	09/01/2010	06/30/2011	0
File required information on rate filings with HHS	Rate Review Manager	09/01/2010	09/30/2011	0

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Work with consultant to develop a plan for aligning current state rate review process with anticipated changes outlined in the Affordable Care Act	Rate Manager	09/01/2010	09/30/2011	0

* Criteria for Evaluating Results or Benefits Expected:

Hiring of Rate Review Manager; completion of rate filing data base; completion of goals and objectives of the rate review manager's position. SERFF expansion implemented in RI. Accurate and timely information submitted to HHS from OHIC

Project Abstract

The Office of the Health Insurance Commissioner (OHIC) of the State of Rhode Island has a comprehensive, innovative and transparent premium rate review process established for all lines of commercial insurance. OHIC reviews the variables, called "rate factors", that health insurers propose to use in their approved rate manuals to calculate premiums quotes, rather than just reviewing the aggregated dollar value of proposed rates. Using rate factors as the basis for premium review has allowed Rhode Island to closely track cost driver trends that comprise premium rates. In addition to actuarial soundness, financial solvency of the insurer, and consumer protection, the Commissioner statutorily must base rate approval, modification, or rejection decisions on insurers' fair treatment of providers and their efforts to improve the affordability, quality and accessibility of medical care. No other state directs regulators to consider these broad health policy factors.

OHIC proposes to use federal funds available to states through the US Department of Health Human Services' (HHS) Premium Review Grant program to accomplish three goals: (1) expand the scope of current rate review and approval activities; (2) enhance the rate review process through staffing; and (3) improve consumer protection standards and communications in the rate review process. These goals align with HHS' objectives for Cycle I funding:

> (1) *Thorough evaluation of proposed health insurance rate increases and, to the extent permitted by law, (dis)approval through a comprehensive rate review process that is meaningful and transparent to all stakeholders; and*
> (2) *Infrastructure development to collect, analyze, and report to the Secretary critical information about rate filings and the review and, to the extent permitted by law, the approval and disapproval process.*

To attain these goals a rate review manager will be hired by OHIC to oversee all rate review activities, which includes obtaining filing and posting decisions, working with the Commissioner and Executive Counsel to review filings, coordinating communication with insurers and stakeholders related to the rate review and collecting and reporting information to The Department of Health and Human Services. The Office's extensive experience with rate review has led it to focus on how the rate review process can address systemic cost drivers. To that end, OHIC will use these funds to monitor efforts to improve health insurance premium affordability and conduct analyses that support and inform rate review decisions. Finally, OHIC will contract with a community partner to engage the public in the rate review process and will enhance its web site to improve consumer access.

To accomplish these rate review enhancements, OHIC has requested $1,000,000 from the Premium Review Grant. $855,000 will fund subcontracts with experts to complete the activities described above. $109,600 will be dedicated to hiring a rate review manager to enhance OHIC's current staffing capacity. OHIC will direct $18,000 to the National Association of Insurance Commissioners to automate some functions of the System for Electronic Rate and Form Filing. The remaining $17,400 will cover supplies, equipment, and travel associated with grant activities.

OHIC is committed to meeting HHS grant objectives, improving the effectiveness of health insurance rate regulation in Rhode Island, and providing valuable lessons for other states engaged in this process.

Project Narrative Attachments

Attachment A

§ 42-62-13 Rates charged. – (a) The rates proposed to be charged or a rating formula proposed to be used by any insurer or health maintenance organization under this section to employers, the state or any political subdivision of the state, or individuals, shall be filed by the insurer or health maintenance organization at the office of the director of business regulation. This section does not apply to any entity subject to § 27-19-1 et seq., and/or § 27-20-1 et seq. The rates proposed to be charged by those entities shall be governed by the provisions of § 27-19-1 et seq., and/or § 27-20-1 et seq. Within sixty (60) days after receipt of the application, the director, or the director's designee, may hold a hearing upon not less than ten (10) days' written notice prior to the hearings. The notice shall contain a description of the rates proposed to be charged, and a copy of the notice shall be sent to the applicant and to the consumer protection unit of the department of attorney general. At any hearing held under this section, the applicant shall be required to establish that the rates proposed to be charged or the rating formula proposed to be used are consistent with the proper conduct of its business and with the interest of the public. Any documents presented in support of a filing of proposed rates under this section shall be made available for public examination at any time and place that the director may deem reasonable. The director, or the director's designee, upon that hearing may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance and require the production of all books, papers, records, correspondence, or other documents which he or she deems relevant. Any designee who shall conduct a hearing pursuant to this section shall report his or her findings in writing to the director within eighty (80) days of the filing with a recommendation for approval, disapproval, or modification of the rates proposed to be charged by the applicant. The recommended decision shall become part of the record. The director shall make and issue a decision not later than ten (10) days following the issuance of the recommended decision or, if the director hears the application without the appointment of a designee, as soon as is reasonably possible following the completion of the hearing on the proposed rate change. The decision may approve, disapprove, or modify the rates proposed to be charged by the applicant. Insurers requesting changes in rates shall underwrite the reasonable expenses of the department of business regulation in connection with the hearing, including any costs related to advertisements, stenographic reporting, and expert witnesses fees. Notwithstanding any other provisions of law, the filing of proposed rates or a rating formula and the holding and conduct of any hearings in connection with these proposed rates or rating formula shall be pursuant to this section.

(b) Whenever the term "designee" is used in this section, it shall mean a person who is impartial, a member in good standing of the Rhode Island bar and a person who is sufficiently acquainted with the rules of evidence as used in the superior court of the state so as to enable that person to conduct a hearing as designee of the director. The reasonable per diem cost of the designee as appointed by the director shall be paid by the insurers requesting changes in the rates.

Attachment B

§ 27-19-6 Rates charged subscribers – Reserves. – *(a) Public hearings:* The rates proposed to be charged or a rating formula proposed to be used by any corporation organized under this chapter to employers, the state or any political subdivision of the state, or individuals, shall be filed by the corporation at the office of the health insurance commissioner. Within sixty (60) days after receipt of the application, the commissioner, or his or her designee shall hold a hearing on all rates proposed for health insurance coverage offered in the individual market as defined in § 27-18.5-2 upon not less than ten (10) days written notice prior to the hearing. With regard to any other rates subject to the commissioner's jurisdiction the commissioner, or his or her designee, may hold a hearing upon not less than ten (10) days written notice prior to the hearing. The notice shall be published by the commissioner in a newspaper or newspapers having aggregate general circulation throughout the state at least ten (10) days prior to the hearing. The notice shall contain a description of the rates proposed to be charged and a copy of the notice shall be sent to the applicant and to the department of the attorney general. In addition, the applicant shall provide by mail, at least ten (10) days prior to the hearing, notice of the proposed rate increase for health insurance coverage offered in the individual market as defined in § 27-18.5-2 to all subscribers subject to the proposed rate increase.

(b) Filings with the Attorney General's Office: The applicant shall provide a copy of the filing on all rates proposed for health insurance coverage offered in the individual market as defined in § 27-18.5-2 to the Insurance Advocacy Unit of the Attorney General's Office simultaneously with the filing at the office of the health insurance commissioner.

(c) Procedures: At any hearing held under this section, the applicant shall be required to establish that the rates proposed to be charged or the rating formula to be used are consistent with the proper conduct of its business and with the interest of the public.

Rates proposed to be charged by any corporation organized under this chapter shall be sufficient to maintain total reserves in a dollar amount sufficient to pay claims and operating expenses for not less than one month. Those reserves shall be computed as of each December 31st, and a report setting forth the computation shall be submitted to the commissioner together with the corporation's Rhode Island annual statement to the commissioner. Any documents presented in support of a filing of proposed rates under this section shall be made available for inspection by any party entitled to participate in a hearing or admitted as an intervenor in a hearing or such conditions as the commissioner may prescribe provided under this section at a time and at a place as the commissioner may deem reasonable. The commissioner, or his or her designee, upon the hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he or she deems relevant. The commissioner shall issue a decision as soon as is reasonably possible following the completion of the hearing. The decision may approve,

disapprove, or modify the rates proposed to be charged by the applicant. Applicants requesting changes in rates shall underwrite the reasonable expenses of the commissioner in connection with the hearing, including any costs related to advertisements, stenographic reporting, and expert witnesses fees.

(d) The term "designee" as used in this section shall mean a person who is impartial, a member in good standing of the Rhode Island bar and a person who is sufficiently acquainted with the rules of evidence as used in the superior court of the state so as to enable that person to conduct a hearing as designee of the commissioner. The reasonable per diem cost of the designee as appointed by the commissioner shall be paid by the applicant requesting changes in the rates.

Attachment C

§ 27-20-6 Rates charged subscribers – Reserves – Hearing by director. – *(a) Public hearings:* The rates proposed to be charged or a rating formula proposed to be used by any corporation organized under this chapter to its subscribers, employers, the state or any political subdivision of the state, or individuals, shall be filed by the corporation at the office of the health insurance commissioner. Within sixty (60) days after receipt of the application, the commissioner, or his or her designee, shall hold a hearing on all rates proposed for health insurance coverage offered in the individual market as defined in § 27-18.5-2 upon not less than ten (10) days written notice prior to the hearing. With regard to any other rates or rating formula subject to the commissioner's jurisdiction the commissioner, or his or her designee, may hold a hearing upon not less than ten (10) days written notice prior to the hearing. The notice shall be published by the commissioner in a newspaper or newspapers having aggregate general circulation throughout the state at least ten (10) days prior to the hearing. The notice shall contain a description of the rates proposed to be charged and a copy of the notice shall be sent to the applicant and to the department of the attorney general. In addition, the applicant shall provide by mail, at least ten (10) days prior to the hearing, notice of the proposed rate increase for health insurance coverage offered in the individual market as defined in § 27-18.5-2 to all subscribers subject to the proposed rate increase.

(b) Filings with the Attorney General's Office: The applicant shall provide a copy of the filing on all rates proposed for health insurance coverage offered in the individual market as defined in § 27-18.5-2 or for a Medicare supplement policy as defined in § 27-18.2-1 to the Insurance Advocacy Unit of the Attorney General's Office simultaneously with the filing at the office of the health insurance commissioner.

(c) Procedures: At any hearing held under this section, the applicant shall be required to establish that the rates proposed to be charged or the rating formula proposed to be used are consistent with the proper conduct of its business and with the interest of the public.

Rates proposed to be charged by any corporation organized under this chapter shall maintain total reserves in a dollar amount sufficient to pay claims and operating expenses for not less than one month. Those reserves shall be computed as of each December 31st, and a report setting forth the computation shall be submitted to the commissioner together with the corporation's Rhode Island annual statement to the insurance commissioner of the state of Rhode Island. Any documents presented in support of a filing of proposed rates under this section shall be made available for inspection by any party entitled to participate in a hearing or admitted as an intervenor in a hearing on such conditions as the commissioner may prescribe provided pursuant to this section at a time and at a place as the commissioner may deem reasonable. The commissioner, or his or her designee, upon the hearing, may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which the director deems relevant. The commissioner shall issue a decision as

soon as is reasonably possible following completion of the hearing. The decision may approve, disapprove, or modify the rates proposed to be charged by the applicant. Applicants requesting changes in rates shall underwrite the reasonable expenses of the commissioner in connection with the hearing, including any costs related to advertisements, stenographic reporting, and expert witnesses fees.

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Attachment D

§ 42-14.5-1 Health insurance commissioner. – There is hereby established, within the department of business regulation, an office of the health insurance commissioner. The health insurance commissioner shall be appointed by the governor, with the advice and consent of the senate. The director of business regulation shall grant to the health insurance commissioner reasonable access to appropriate expert staff.

Attachment E

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 ***Encouraging Fair Treatment of Health Care Providers***

(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

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[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.

(A) can be made in a manner that will

(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: December 15, 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.

Attachment F

§ 27-50-5 Restrictions relating to premium rates. – (a) Premium rates for health benefit plans subject to this chapter are subject to the following provisions:

(1) Subject to subdivision (2) of this subsection, a small employer carrier shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Age;

(ii) Gender; and

(iii) Family composition;

(2) The adjustment for age in paragraph (1)(i) of this subsection may not use age brackets smaller than five (5) year increments and these shall begin with age thirty (30) and end with age sixty-five (65).

(3) The small employer carriers are permitted to develop separate rates for individuals age sixty-five (65) or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates are subject to the requirements of this subsection.

(4) For each health benefit plan offered by a carrier, the highest premium rate for each family composition type shall not exceed four (4) times the premium rate that could be charged to a small employer with the lowest premium rate for that family composition.

(5) Premium rates for bona fide associations except for the Rhode Island Builders' Association whose membership is limited to those who are actively involved in supporting the construction industry in Rhode Island shall comply with the requirements of § 27-50-5.

(6) For a small employer group renewing its health insurance with the same small employer carrier which provided it small employer health insurance in the prior year, the combined adjustment factor for age and gender for that small employer group will not exceed one hundred twenty percent (120%) of the combined adjustment factor for age and gender for that small employer group in the prior rate year.

(b) The premium charged for a health benefit plan may not be adjusted more frequently than annually except that the rates may be changed to reflect:

(1) Changes to the enrollment of the small employer;

(2) Changes to the family composition of the employee; or

(3) Changes to the health benefit plan requested by the small employer.

(c) Premium rates for health benefit plans shall comply with the requirements of this section.

(d) Small employer carriers shall apply rating factors consistently with respect to all small employers. Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans. Two groups that are otherwise identical, but which have different prior year rate factors may, however, have rating factors that produce premiums that differ because of the requirements of subdivision 27-50-5(a)(6). Nothing in this section shall be construed to prevent a group health plan and a health insurance carrier offering

health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, including those included in affordable health benefit plans, provided that the resulting rates comply with the other requirements of this section, including subdivision (a)(5) of this section.

The calculation of premium discounts, rebates, or modifications to otherwise applicable copayments or deductibles for affordable health benefit plans shall be made in a manner consistent with accepted actuarial standards and based on actual or reasonably anticipated small employer claims experience. As used in the preceding sentence, "accepted actuarial standards" includes actuarially appropriate use of relevant data from outside the claims experience of small employers covered by affordable health plans, including, but not limited to, experience derived from the large group market, as this term is defined in § 27-18.6-2(19).

(e) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.

(f) The health insurance commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including regulations that assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design or coverage (not including differences due to the nature of the groups assumed to select particular health benefit plans or separate claim experience for individual health benefit plans) and to ensure that small employer groups with one eligible subscriber are notified of rates for health benefit plans in the individual market.

(g) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(2) The provisions relating to renewability of policies and contracts;

(3) The provisions relating to any preexisting condition provision; and

(4) A listing of and descriptive information, including benefits and premiums, about all benefit plans for which the small employer is qualified.

(h) Each small employer carrier shall maintain at its principal place of business 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.

(2) Each small employer carrier shall file with the commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. The certification shall be

in a form and manner, and shall contain the information, specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(3) A small employer carrier shall make the information and documentation described in subdivision (1) of this subsection available to the commissioner 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.

(4) For the wellness health benefit plan described in § 27-50-10, the rates proposed to be charged and the plan design to be offered by any carrier shall be filed by the carrier at the office of the commissioner no less than thirty (30) days prior to their proposed date of use. The carrier shall be required to establish that the rates proposed to be charged and the plan design to be offered are consistent with the proper conduct of its business and with the interest of the public. The commissioner may approve, disapprove, or modify the rates and/or approve or disapprove the plan design proposed to be offered by the carrier. Any disapproval by the commissioner of a plan design proposed to be offered shall be based upon a determination that the plan design is not consistent with the criteria established pursuant to subsection 27-50-10(b).

(i) The requirements of this section apply to all health benefit plans issued or renewed on or after October 1, 2000.

Attachment G

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 11
SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY REGULATION

Table of Contents

Section 1 ***Statement of Authority and Purpose***

This regulation is promulgated pursuant to the authority granted to the health insurance commissioner under R.I. Gen. Laws §§ 27-19-6, 27-20-6, 27-50-1 *et seq.*, 42-14-5, 42-14-17, 42-14.5-1 *et seq.* and 42-62-13.

This regulation is intended to implement the provisions of Title 27, Chapter 50, the "Small Employer Health Insurance Availability Act" (the "Act"). 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 Act and this regulation are intended to promote broader spreading of risk in the small employer marketplace and to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of the Act and this regulation.

Section 2 ***Definitions***

All words or phases used in this regulation already defined in R.I. Gen. Laws § 27-50-3 shall have the meaning therein. In addition, as used in this regulation:

(a) "COBRA continuation coverage" means insurance continuation benefits provided under Title X of Pub. L. No. 99-272, as amended.

(b) "Case characteristic" means the characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer.

(c) "Commissioner" shall mean the health insurance commissioner.

(d) "Covered employee" means an eligible employee who is or was provided coverage under a group health plan.

(e) "Individual health insurance policy" means health insurance coverage offered to an individual in his or her capacity as an individual and not in connection with a group health benefit plan or as a small employer.

(f) "New entrant" includes an eligible employee, or the dependent of an eligible employee, who becomes eligible to participate in a health benefit plan sponsored by a small employer in accordance with the special enrollment provisions under R.I. Gen. Laws § 27-50-7(d)(7) or (8).

(g) "OHIC" or "Office" means the Office of the Health Insurance Commissioner.

(h) "Qualified beneficiary" means, with respect to a covered employee under a group health plan, an individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan:

(1) as the spouse of the covered employee;

(2) as the dependent child of the covered employee, or

(3) a child who is born to or placed for adoption with the covered employee during the period of COBRA continuation coverage.

(i) "Qualifying event" means, with respect to a covered employee, any of the following events that, but for COBRA continuation coverage, would result in the loss of coverage of a qualified beneficiary:

(1) the death of the covered employee;

(2) the termination, except for the employee's gross misconduct, or reduction of hours, of the covered employee's employment;

(3) the divorce or legal separation of the covered employee from the employee's spouse;

(4) the covered employee becoming entitled to benefits under Title XVIII of the Social Security Act; or

(5) a dependent child ceasing to be a dependent child under the requirements of the health benefit plan.

(j) "Risk characteristic" means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

Section 3 ***<u>Applicability and Scope</u>***

(a) Applicability.

(1) Except as provided in paragraphs (a)(2) or (a)(3) of this section and Section 11 of this regulation, this regulation shall apply to any health benefit plan, whether provided on a group or individual basis, that:

(A) meets one or more of the conditions set forth in R.I. Gen. Laws § 27-50-4(a); and

(B) provides coverage to one or more employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state.

(2) Individual health insurance; self-employed persons; plans and deductions under the Internal Revenue Code.

(A) The provisions of the Act and this regulation shall not apply to an individual health insurance policy purchased by a self-employed person for himself or herself alone or for that person and his or her spouse and/or family under conditions that do not meet those set forth in R.I. Gen. Laws § 27-50-4(a).

(B) In the case of a self-employed person, the conditions set forth in R.I. Gen. Laws § 27-50-4(a)(4) have been met if:

(i) the health insurance is marketed to the self-employed person in his or her capacity as a self-employed person; or

(ii) the health insurance is marketed to the self-employed person through that person's membership (or potential membership) in an association or trade group for small employers or self-employed persons.

(C) A policy that otherwise meets the requirements of an individual health insurance policy and does not fall under the provisions of the Act and this regulations shall not be considered to meet the requirement of R.I. Gen.

Laws § 27-50-4(a)(3) and therefore be subject to the Act and this regulation solely because:

(i) the policyholder treats the health insurance policy as part of a plan or program under Section 125 of the Internal Revenue Code; provided however, that no portion of the premium is paid by the small employer through such a plan or program; or

(ii) the policyholder elects a deduction under section 162(l) of the Internal Revenue Code.

(3) The provisions of the Act and this regulation shall apply to dental, vision or long term care benefits only as provided for in 45 C.F.R. 146.145.

(b) Relationship to individual health insurance.

(1) Except as provided in paragraph (a)(2) of this section, a carrier that provides individual health insurance policies to one or more of the employees of a small employer shall be considered a small employer carrier and shall be subject to the provisions of the Act and this regulation with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware or should have been aware of such contribution.

(2) In the case of a carrier that provides individual health insurance policies to one or more employees of a small employer, the small employer shall be considered to be an eligible small employer as defined in R.I. Gen. Laws § 27-50-3(kk) and the small employer carrier shall be subject to R.I. Gen. Laws § 27-50-7(b) (relating to guaranteed issue of coverage) if:

(A) the employer qualifies as a small employer under the definitions contained in R.I. Gen. Laws §§ 27-50-3 and 27-50-7;

(B) the small employer contributes directly or indirectly to the premiums charged by the carrier; and

(C) the carrier is aware or should have been aware of the contribution by the employer.

(c) Association or discretionary groups. The provisions of the Act and this regulation shall apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

(d) Number of eligible employees.

(1) If a small employer is issued a health benefit plan under the terms of the Act, the provisions of the Act and this regulation shall continue to apply to the health benefit plan even in the event that the small employer subsequently employs more than fifty eligible employees. A carrier providing coverage to such an employer shall, within sixty days of becoming aware that the employer has more than fifty eligible employees, but no later than the anniversary date of the

employer's health benefit plan, notify the employer that the provisions and protections provided under the Act and this regulation shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

(2) If a health benefit plan is issued to an employer that is not a small employer as defined in the Act, but subsequently the employer becomes a small employer (for any reason including the loss or change of work status of one or more employees), the terms of the Act shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier under the terms of the Act solely because the carrier continues to provide coverage under the health benefit plan to the employer. A carrier providing coverage to such an employer shall, within sixty days of becoming aware that the employer has fifty or fewer eligible employees, notify the employer of the options and protections available to the employer under the Act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

(e) Employees outside of Rhode Island.

(1) If a small employer has employees in more than one state, the provisions of the Act and this regulation shall apply to a health benefit plan issued to that small employer if:

(A) the majority of eligible employees of such small employer are employed in this state; or

(B) the primary business location of the small employer is in this state and no state has a majority of the eligible employees of the small employer.

(2) In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in paragraph (e)(1) of this section, the provisions of paragraph (e)(1) shall be applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect.

(3) If a health benefit plan is subject to the Act and this regulation, the provisions of the Act and this regulation shall apply to all individuals covered under the health benefit plan, whether they reside in this state or in another state.

(f) Small employer carriers not operating in Rhode Island. A carrier that is not operating as a small employer carrier in this state shall not become subject to the provisions of the Act and this regulation solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state.

Section 4 ***Transition or Assumption of Business from Another Carrier***

(a) Approval required for transfer or assumption insurance risk. A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless:

(1) the transaction has been approved by the insurance commissioner of the state of domicile of the assuming carrier or the OHIC if the assuming carrier is domiciled in Rhode Island;

(2) the transaction has been approved by the insurance commissioner of the state of domicile of the ceding carrier or the OHIC if the ceding carrier is domiciled in Rhode Island; and

(3) the transaction otherwise meets the requirements of the Act and this regulation.

(b) Approval of the transaction—carriers domiciled in Rhode Island. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation or risk of one or more small employer health benefit plans from another carrier shall make a filing for approval with the health insurance commissioner at least sixty days prior to the date of the proposed assumption. The commissioner may approve the transaction if the commissioner finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this regulation. The commissioner shall not approve the transaction until at least thirty days after the date of the filing, unless the ceding carrier is in hazardous financial condition. If the ceding carrier is in hazardous financial condition, the commissioner may approve the transaction as soon as the commissioner deems appropriate after the filing.

(c) Requirements for the filing. The filing required under paragraph (b) of this section shall:

(1) describe whether the health benefit plans being assumed are currently available for purchase by small employers;

(2) describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed;

(3) describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed;

(4) describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed; and

(5) include any other information required by the health insurance commissioner.

(d) Informational filing required in other states. A small employer carrier required to make a filing under paragraph (b) of this section shall also make an informational filing with the insurance commissioner of each state in which there are small employer health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under paragraph (b) of this section and shall include at least the information specified in paragraph (c) of this section for the small employer health benefit plans in that state.

(e) Notice of the transaction—carriers not domiciled in Rhode Island. A small employer carrier not domiciled in Rhode Island shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in

this state unless it has provided a notice to the health insurance commissioner at least sixty days prior to the date of the proposed assumption that contains the information specified in paragraph (c) of this section for the health benefit plans covering small employers in this state.

(f) Transfer. A small employer carrier making a transfer pursuant to this section may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier into which the health benefit plans have been transferred.

(g) New rate for transfers. The premium rate for an assumed small employer health benefit plan shall not be modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to this section. Upon transfer, the assuming small employer carrier shall calculate a new premium rate for the health benefit plan from the rate manual required under Section 5 of this regulation.

(h) Eligibility requirements may not be more stringent. An assuming carrier may not apply eligibility requirements, including minimum participation and contribution requirements, with respect to an assumed health benefit plan or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan that are more stringent than the requirements applicable to such health benefit plan prior to the assumption.

(i) Legal obligations, authorizations and protections. Nothing in this section or in the Act is intended to:

(1) reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in R.I. Gen. Laws §§ 27-53.1-1 *et seq.* of the ceding or assuming carrier related to the transaction;

(2) authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or

(3) reduce or diminish the protections related to an assumption reinsurance transaction provided in R.I. Gen. Laws §§ 27-53.1-1 *et seq.* or otherwise provided by law.

Section 5 ***<u>Rate Manual and Restrictions Relating to Premium Rates</u>***

(a) Rate manual. A small employer carrier shall develop a rate manual based on an adjusted community rate that may vary the adjusted community rate only for the following case characteristics:

(1) age;

(2) gender;

(3) family composition; and

(4) health status, provided that as of June 1, 2000 the carrier varied rates by health status and provided further such carrier (i) varies the adjusted community rate by health status only as provided in R.I. Gen. Laws § 27-50-5(a), (ii) such variation does not result in rates more than ten percent higher or lower than the

rates without consideration of health status, and (iii) the adjustments are to be applied uniformly to all small employers covered by the carrier.

(b) Health status adjustment.

(1) The health status adjustment described in paragraph (a)(4) of this section is limited to an amount that is at maximum equal to plus or minus ten percent from the age/gender adjusted community rate, subject to all other limitations imposed by the Act and this regulation. Use of the health status adjustment may not result in rates that are more than ten percent lower or higher than they would have been without the use of health status (i.e., health status may not vary rates by more than plus or minus ten percent from the average rate previously determined).

(2) In order to apply health status adjustments on a basis consistent with the requirements of the Act and this regulation, a carrier must determine the dollar amount of deviations for health status from average rates, and take steps to ensure that the total of downward deviations due to health status is approximately equal to the total of upward deviations due to health status. This may be done on either a monthly or an annual basis.

(3) No later than January 1, 2009, all carriers shall use standardized health status data collection tools described in paragraph (a) of Section 13 of this regulation for the purposes of obtaining information to apply the health status factor adjustment.

(c) Family composition. Each small employer carrier shall include all categories of family composition set forth in the Act in each health benefit plan offered to every small employer. Those categories are (1) the enrollee; (2) the enrollee, spouse and children; (3) the enrollee and spouse; or (4) the enrollee and children.

(d) Requirement to maintain rating information. In accordance with R.I. Gen. Laws § 27-50-5(h), a small employer carrier shall maintain rating information and documentation relating to rating practices and renewal underwriting practices and make it available to the health insurance commissioner. Such information shall be provided to the commissioner within tens day of a written request. The small employer carrier is not required to file such information with the commissioner for approval prior to use.

(e) Rates computed solely from the rate manual. Except as provided in R.I. Gen. Laws § 27-50-5(a)(6), base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

(f) Relationship among the base premium rates. The rate manual, developed pursuant to this section, shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan.

(g) Differences among base premium rates. Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans, except as otherwise specifically permitted under the Act, and shall not be based in any manner on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

(h) No application fees; in general. Except as provided in paragraph (i) of this section, a premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge.

(i) Applications fees charged; exception to the prohibition. A carrier may charge a separate fee with respect to a health benefit plan (but only one fee with respect to such plan) provided the fee is no more than five dollars per month per employee and is applied in a uniform manner to each health benefit plan.

(j) Allocation of expenses—statutory plans. A small employer carrier shall allocate administrative expenses to any health benefit plans required to be offered by R.I. Gen. Laws § 27-50-1 *et seq.* on a no less favorable basis than expenses are allocated to other health benefit plans.

(k) Allocation of administrative expenses—the rate manual. The rate manual developed pursuant to this section shall describe the method of allocating administrative expenses to the health benefit plans for which the manual was developed.

(l) Retention of rate manuals. The rate manual developed pursuant to this section shall be maintained by the carrier for a period of six years. Updates and changes to the manual shall be maintained with the manual.

(m) Compliance with guidance. The rate manual and rating practices of a small employer carrier shall comply with all guidelines issued by the health insurance commissioner, including those issued pursuant to bulletins and orders adopting market conduct examination reports.

(n) Employer does not meet "small employer" definition. If an employer does not meet the definition of a "small employer" under R.I. Gen. Laws § 27-50-3(kk), the small employer carrier shall rate the employer as a large employer, and the provisions of R.I. Gen. Laws § 27-50-5 and this section shall not apply.

Section 6 ***<u>Requirement to Insure Entire Group</u>***

(a) Coverage for each eligible employee and dependent. A small employer carrier that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in paragraph (b) of this regulation, the small employer carrier shall provide the same health benefit plan to each such employee and dependent.

(b) Offering one or more health benefit plans. A small employer carrier may offer the employees of a small employer the option of choosing one or more health benefit plans, provided that each employee may choose any of the offered plans. Except as provided in R.I. Gen. Laws § 27-50-7(d) (with respect to exclusions for preexisting conditions), the choice among benefit plans may not be limited, restricted or

conditioned based upon the risk characteristics or a health status-related factor of the employees or their dependents.

(c) List of eligible employees and dependents.

(1) A small employer carrier shall require each small employer that initially applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees as defined in R.I. Gen. Laws § 27-50-3(m). The small employer carrier shall require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) to verify the information required hereunder. Thereafter, eligibility documentation shall only be required for new employees and/or dependents who apply for coverage. Complete recertification of all eligible employees and dependents, or recertification of a particular employee and/or dependent may be required by the carrier at any time.

(2) No later than January 1, 2009, all carriers shall use standardized certification tools described in paragraph (b) of Section 13 of this regulation for the purposes of complying with paragraph (c)(1) of this section.

(d) Waivers.

(1) A small employer carrier shall obtain a waiver from each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer.

(2) The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan.

(3) The waiver form shall:

(A) require that the reason for declining coverage be stated on the form;

(B) include a written warning of the penalties imposed on late enrollees; and

(C) include a statement informing the eligible employee of their special enrollment rights, if any, under R.I. Gen. Laws § 27-50-7(d)(7) or (8).

(4) In the event that an eligible employee or dependent refuses to sign the waiver required hereunder, the small employer must certify such refusal in writing.

(5) Waivers and certifications of refusal to sign waivers shall be maintained by the small employer carrier for a period of six years.

(e) Refusal to provide the list of eligible employees and dependants. A small employer carrier shall not issue coverage (either new coverage or renewal coverage) to a small employer that refuses to provide the list of eligible employees and dependants pursuant to paragraph (c) of this section or a waiver required under paragraph (d) of this section. If a small employer fails to supply adequate supporting documentation, the carrier is required to presume that the employer is not eligible for issuance or renewal of coverage as a small employer.

Individuals whose small employer benefits are declined or non-renewed shall be offered conversion, continuation or individual coverage as required under other applicable laws and regulations.

Section 7 ***Application to Reenter State***

(a) Petition to be reinstated. A carrier that has been prohibited from writing coverage for small employers in this state pursuant to R.I. Gen. Laws § 27-50-6(c) may not resume offering health benefit plans to small employers in this state until the carrier has filed a petition with the health insurance commissioner seeking to be reinstated as a small employer carrier and the petition has been approved by the commissioner. In reviewing a petition to reinstate, the commissioner may ask for such information and assurances as the commissioner deems reasonable and appropriate.

(b) Carrier doing business in only one established geographic service area. In the case of a small employer carrier doing business in only one established geographic service area of the state, if the small employer carrier elects to discontinue offering a health benefit plan under R.I. Gen. Laws § 27-50-6(a)(5), the small employer carrier shall be prohibited from offering health benefit plans to small employers in any part of the service area for a period of five years beginning on the date the carrier ceased offering new coverage in that established geographic service area of the state. In addition, the small employer carrier shall not offer health benefit plans to small employers in any other geographical area of the state without the prior approval of the health insurance commissioner. In considering whether to grant approval to offer health benefit plans, the commissioner may ask for such information and assurances as the commissioner deems reasonable and appropriate.

Section 8 ***Certification and Disclosure of Prior Creditable Coverage***

(a) Creditable coverage.

(1) In general.

(A) Small employer carriers shall provide written certification of creditable coverage, as that term is defined in R.I. Gen. Laws § 27-50-3(i), to individuals in accordance with this section.

(B) A small employer carrier shall be deemed to have satisfied the certification requirements of this section if another person provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period has been provided by the other person.

(C) To the extent coverage under a health benefit plan consists of group health benefit plan coverage, the plan shall be deemed to have satisfied the certification requirements of this section if the small employer carrier offering the coverage is required to provide the certificates of creditable coverage to individuals pursuant to an agreement between the plan and the carrier.

(D) A small employer carrier is not required to provide information regarding health benefit plan coverage provided to an individual by another person.

(E) If an individual's coverage under a policy ceases before the individual's coverage under the group health plan ceases, the entity that issued the policy shall provide sufficient information to the small employer carrier, or to another person designated by the carrier, to enable the carrier, or other person, to provide a certificate that reflects the period of coverage under the policy, after the individual's coverage under the group health plan ceases.(i) The provision of the information pursuant to paragraph (a)(1)(E) of this section to the carrier shall satisfy the entity's obligation to provide an automatic certificate pursuant to paragraphs (a) and (b) of this section.

(ii) The entity providing the information pursuant to paragraph (a)(1)(E) of this section shall cooperate with the carrier in responding to any request made under paragraph (f)(2) of this section.

(iii) If the individual's coverage under the group health plan ceases at the time the individual's coverage under the policy ceases, the entity that issued the policy shall provide an automatic certificate pursuant to paragraphs 8(a)(2) or (3) of this section.

(iv) An entity that issued the policy may presume that an individual whose coverage ceases at a time other than the effective date for changing enrollment options has ceased to be covered under the group health plan.

(2) Certification of creditable coverage.

(A) A small employer carrier shall provide a certification of creditable coverage, without charge, to eligible employees or dependents who are or were covered under the group health plan as follows:

(i) for an individual who is a qualified beneficiary entitled to elect COBRA continuation coverage, automatically at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage; or

(ii) for an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, automatically at the time the individual ceases to be covered under the group health plan.

(B) A small employer carrier satisfies the requirements of paragraph (a)(2)(A)(i) of this section if the carrier provides the certificate no later than the time a notice is required to be furnished for a qualifying event as specified in federal regulations.

(C) A small employer carrier satisfies paragraph (a)(2)(a)(ii) of this section if the carrier provides the certification within a reasonable time after

coverage under the group health plan ceases.(D) For an individual who is entitled to elect to continue coverage under a state program similar to COBRA and who receives the certificate pursuant to paragraph (a)(2)(a)(ii) of this section not later than the time a notice is required to be furnished under the state program, the certification shall be deemed to be provided within a reasonable time period after the cessation of coverage under the plan.

(3) COBRA continuation coverage.

(A) For an individual who is a qualified beneficiary and has elected COBRA continuation coverage, or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage, a small employer carrier shall provide a certificate automatically at the time the individual's COBRA continuation coverage under the plan ceases.

(B) A small employer carrier satisfies paragraph (a)(3)(a) of this section if the carrier provides the certificate within a reasonable time after the coverage ceases or after the expiration of any grace period for nonpayment of premiums.

(C) A small employer carrier shall provide a certificate under paragraph (a)(3)(a) of this section to an individual regardless of whether the individual previously has received a certificate under paragraph(a)(2)(a)(i) of this section.

(4) Request for a certificate.

(A) Procedure.

(i) A small employer carrier shall provide a certificate at the time a request is made by or on behalf of an individual if the request is made within twenty-four months after the date the individual's coverage has ceased under the plan.

(ii) Each small employer carrier shall establish a reasonable procedure for individuals to request and promptly receive certificates hereunder.

(B) Upon receipt of the request, the small employer carrier shall provide the certificate by the earliest date that the carrier, acting in a reasonable and prompt fashion, can provide the certificate.

(C) A small employer carrier shall provide a certificate as required under this Regulation even if the individual previously received such a certificate.

(b) Requirements.

(1) Certificate must be in writing; exceptions.

(A) Except as provided in paragraph (b)(1)(B) of this section, a certificate provided under paragraph (a) of this section shall be in writing.

(B) A written certificate is not required to be provided pursuant to paragraphs (a)(2), (3), or (4) of this section if:

(i) an individual is entitled to receive a certificate;

(ii) the individual requests that the certificate be sent to another health benefit plan instead of the individual;

(iii) the health benefit plan that would otherwise receive the written certificate agrees to accept the information described in Section(8)(b)(2) through means other than a written certificate; and

(iv) the receiving health benefit plan receives the information from the sending health benefit plan in such form within the time periods required under paragraphs (a)(2), (3), or (4) of this section.

(2) A certificate provided pursuant to this paragraph (b) of this section shall include the following:

(A) the date the certificate was issued;

(B) the name of the group health plan that provided the coverage described in the certificate;

(C) the name of the participant and/or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for, or includes, a dependent;

(D) the name, address, and telephone number of the plan administrator required to provide the certificate;

(E) the telephone number to call for further information regarding the certificate if different from the phone number of the plan administrator;

(F) either:

(i) a statement that the individual has at least eighteen months of creditable coverage, disregarding days of creditable coverage before a significant break in coverage; or

(ii) the date any waiting period or affiliation period, if applicable, began and the date creditable coverage began; and

(G) the date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

(3) If an automatic certificate is provided pursuant to paragraph (a)(2) or (3) of this section, the period included on the certificate shall be the last period of continuous coverage ending on the date the coverage ceased.

(4) For a certificate requested pursuant to paragraph (a)(4) of this section, the certificate must be provided for each period of continuous coverage ending within the twenty-four month period ending on the

date of the request or continuing on the date of the request. A separate certificate may be provided for each period of continuous coverage.

(5) A certificate may provide the information required pursuant to paragraph (b)(2) of this section with respect to both a participant and the participant's dependents if the information is identical for each individual. If the information required pursuant to paragraph (b)(2) of this section is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(6) Appendix B contains a model certificate that a small employer carrier may use to satisfy the requirements of paragraph (b)(2) of this section.

(7) A small employer carrier is not required to provide a certificate with respect to excepted benefits, as described in R.I. Gen. Laws § 27-50-3(v)(2), (3), (4) and (5), except if the excepted benefits are being provided concurrently with other creditable coverage. Under such circumstances, a small employer carrier may be required to disclose information concerning the benefits under paragraph (f) of this section.(c) Providing the certificate of coverage.

(1) Small employer carriers may provide a certificate required to be provided pursuant to this section by first-class mail.

(2) The address where the certificate is sent.

(A) If a small employer carrier provides the certificate or certificates to the participant and the participant's spouse at the participant's last known address, the carrier has satisfied the requirements of this Section with respect to all individuals residing at that address.

(B) If the last known address of a dependent of the participant is different from the participant's last known address, a small employer carrier shall provide a separate certificate to the dependent at the dependent's last known address.

(C) If a small employer carrier is providing separate certificates by mail to individuals who reside at the same address, the carrier is not required to mail each certificate separately.

(3) Designating another individual or person to receive the certificate.

(A) If a small employer carrier is required to provide a certificate automatically to an individual pursuant to paragraphs (a)(2) or (3) of this section, and the individual entitled to receive the certificate designates another individual or person to receive the certificate, the carrier may provide the certificate to the designated party.

(B) If a small employer carrier is required to provide a certificate upon request pursuant to paragraph (a)(4) of this section and the individual entitled to receive the certificate designates another individual or person to receive

the certificate, the carrier shall provide the certificate to the designated party.

(d) Reasonable efforts.

(1) A small employer carrier shall use reasonable efforts to determine the information needed for a certificate relating to dependent coverage.

(2) For certificates required to be provided automatically pursuant to paragraphs (a)(2) or (3) of this section, an individual certificate is not required to be provided until the small employer carrier knows or, using reasonable efforts, should know of the dependent's cessation of coverage under the plan.

(3) If a certificate provided by a small employer carrier does not provide the name of a dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph(g)(5) of this regulation for demonstrating dependent status. In addition, an individual may, if necessary, use the procedures described in paragraph (g)(5) of this section to demonstrate that a child was enrolled within thirty days of birth, adoption or placement for adoption.

(e) Certificate provided for coverage not subject to the Act. Small employer carriers shall provide certificates of creditable coverage to individuals under this section even if the coverage is provided in connection with an entity or program that is not itself required to provide a certificate because the entity or program is not subject to the Act. This requirement applies to coverage provided in connection with: creditable coverage described in R.I. Gen. Laws § 27-50-3(j)(1)(b) through (j) and coverage subject to Section 2721(b)(1)(B) of the PHSA.

(f) Alternative method of counting creditable coverage—information required. If an individual enrolls in a group health plan with respect to which the small employer carrier uses the alternative method of counting creditable coverage described in R.I. Gen. Laws § 27-50-7(d)(3) and the individual provides a certificate received pursuant to this section, at the request of the small employer carrier through which the individual has enrolled, the entity that provided the certificate to the individual shall promptly disclose to the carrier the information sufficient to identify to the small employer carrier the categories of benefits with respect to which the carrier is using the alternative method of counting creditable coverage. The small employer carrier requesting the information may identify specific information that the carrier reasonably needs in order to determine the individual's creditable coverage with respect to a category. The entity providing the information may charge the small employer carrier requesting the information for the reasonable cost of providing the information.

(g) Establishing creditable coverage through other means.

(1) An individual may establish creditable coverage through means other than a certificate if:

(A) the accuracy of the certificate is contested; or

(B) a certificate is unavailable at the time the certificate is needed by the individual.

(2) Paragraph (g)(1) of this section applies, but is not limited to, the following circumstances:

(A) an entity has failed to provide a certificate within the required time period;

(B) the individual has creditable coverage, but an entity may not be required to provide a certificate under this section;

(C) the individual has an urgent medical condition that requires a determination as to creditable coverage prior to the time the individual can provide a certificate to the health benefit plan; or

(D) the individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(3) A small employer carrier shall take into account all of the information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion period.

(4) A small employer carrier shall treat the individual as having provided a certificate pursuant to this section if the individual:

(A) attests to the period of creditable coverage;

(B) presents relevant corroborating evidence of some creditable coverage during the period; and

(C) cooperates with the carrier's efforts to verify the individual's coverage.

(5) A small employer carrier may refuse to credit coverage where an individual fails to cooperate with the carrier's efforts to verify the individual's coverage. The carrier shall not consider the individual's inability to obtain a certificate as evidence of the absence of creditable coverage.

(6) For the purpose of paragraphs (g)(4)(C) and (g)(5) of this section, "cooperate" includes providing, upon request of the small employer carrier, a written authorization for the carrier to request a certificate on behalf of the individual and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage.

(7) Documents that may establish creditable coverage and waiting or affiliation periods in the absence of a certificate include:

(A) explanation of benefit (EOB) or other correspondence from a carrier indicating health benefit plan coverage;

(B) pay stubs showing a payroll deduction for health benefit plan coverage;

(C) a health insurance identification card;

(D) a certificate of coverage under a group health plan;

(E) records from health care providers, indicating health benefit plan coverage;

(F) third party statements verifying periods of health benefit plan coverage; and

(G) any other relevant documents that evidence periods of health benefit plan coverage.

(8) In addition to documentation set out in paragraph (g)(7) of this section, creditable coverage and waiting or affiliation period information may be established through other means, such as by a telephone call from the carrier or provider to a third party verifying creditable coverage.

(9) If, in the course of providing evidence of creditable coverage, including a certificate of creditable coverage pursuant to this section, an individual is required to demonstrate dependent status, the small employer carrier shall treat the individual as having furnished a certificate showing the dependent status if the individual:

(A) attests in writing to the dependency and period of dependency; and

(B) the individual cooperates with the carrier's efforts to verify dependent status.

(10) The procedures used by a small employer carrier pursuant to this section to determine creditable coverage shall apply to determine an individual's creditable coverage with respect to any category under paragraph (f) of this section relating to determining creditable coverage under the alternative method.

(h) Determination of creditable coverage; preexisting condition exclusion.

(1) Within a reasonable time period following the date of receiving information under this section with respect to creditable coverage of an individual, the small employer carrier shall make a determination regarding the individual's period of creditable coverage and notify the individual of the determination in accordance with the requirements of section (h)(3) of this section.

(2) Whether a determination and notification regarding an individual's creditable coverage is made within a reasonable time period shall be determined based on the relevant facts and circumstances, including whether the carrier's application of a preexisting condition exclusion would prevent the individual from having access to urgent medical care services.

(3) A small employer carrier seeking to impose a preexisting condition exclusion shall disclose, in writing, to the individual its determination of any preexisting condition exclusion period that applies to the individual and the basis for the determination, including the source and substance of any information on which the carrier relied in making the determination. A small employer carrier shall include in the disclosure an explanation of any appeal procedures established by

the carrier and provide the individual with a reasonable opportunity to submit additional evidence of creditable coverage.

(4) Nothing in this paragraphs (g) or (h) of this section shall prevent a small employer carrier from modifying an initial determination of creditable coverage for an individual if the carrier determines that the individual did not have the creditable coverage, as claimed, if:

(A) the carrier provides a notice of reconsideration to the individual; and

(B) until the final determination regarding creditable coverage, the carrier, for the purpose of approving access to medical care, acts in a manner consistent with the initial determination.

Section 9 ***<u>Restrictive Riders</u>***

A restrictive rider, endorsement or other provision that would violate the provisions of R.I. Gen. Laws § 27-50-7(d)(10)(iii) is prohibited. Furthermore, except as permitted in R.I. Gen. Laws § 27-50-7(d)(2), a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions or services otherwise covered by the plan.

Section 10 ***<u>Rules Related to Fair Marketing</u>***

(a) Marketing of health plans. A small employer carrier shall actively market each of its health benefit plans to small employers in this state.

(b) Offering health plans. A small employer carrier shall actively offer all health benefit plans it actively markets in this state to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. The offer may be provided directly to the small employer or delivered through a producer. The offer shall be in writing and shall include at least the following information:

(1) a general description of the benefits contained in any health benefit plans being offered to the small employer; and

(2) information describing how the small employer may enroll in the plans.

(c) Price quote. A small employer carrier shall provide a price quote to a small employer directly or through an authorized producer within ten working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small employer directly or through an authorized producer within five working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.

(d) Requirement to issue. Subject to R.I. Gen. Laws § 27-50-7(b)(2), a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan.

(e) Use of group size or any health status to determine eligibility prohibited. A small employer carrier may not directly or indirectly use group size or any health status-related factor as criteria for establishing eligibility for a health benefit plan.

(f) Toll-free number.

(1) A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state.

(2) The toll-free number shall be included in the local telephone directory and identified as a small employer health insurance contact number.

(3) The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

(g) Membership or contribution to association or group. The small employer carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement.

(h) Requirement or condition to purchase other insurance. A small employer carrier may not require, as a condition of the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

(i) Initial determination of compliance with Act. Carriers offering individual and group health benefit plans in this state shall be responsible for initially determining whether the plans are subject to the requirements of the Act and this regulation. The final determination of compliance rests with the health insurance commissioner.

(j) Required information from applicants. Carriers shall elicit the following information from applicants for such plans at the time of application:

(1) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

(2) Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under Section 162 (other than Section 162(l)), Section 125 or Section 106 of the United States Internal Revenue Code.

(k) Failure to collect information. If a small employer carrier fails to comply with paragraph (j) of this section, the small employer carrier shall be deemed to be on notice of any information that could reasonably have been obtained if the small employer carrier had complied with paragraph (j) of this section..

Section 11 ***Status of Carriers as Small Employer Carriers***

(a) Filing required. Each carrier providing health benefit plans in this state shall make a filing with the health insurance commissioner indicating whether the carrier intends to operate as a small employer carrier in this state under the terms of this regulation. There is no application form nor requirement for approval. A letter stating the carrier's intention to operate in Rhode Island as a small employer carrier is sufficient. If a carrier has already made such a filing with either the commissioner or the predecessor to the OHIC, the Department of Business Regulation, the carrier need not make a new filing.

(b) Prohibition on providing coverage. Subject to paragraph (c) of this section, a carrier shall not offer health benefit plans to small employers, or continue to provide coverage under health benefit plans previously issued to small employers in this state, unless the filing provided pursuant to paragraph (a) of this section indicates that the carrier intends to operate as a small employer carrier in this state.

(c) Exceptions. If the filing made pursuant paragraph (a) of this section indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to small employers in this state only if the carrier complies with the following provisions:

(1) the carrier complies with the requirements of the Act with respect to each of the health benefit plans previously issued to a small employer by the carrier;

(2) the carrier provides coverage to each new entrant to a health benefit plan previously issued to a small employer by the carrier; and

(3) the carrier complies with the requirements of R.I. Gen. Laws § 27-50-15 and Sections 9 and 12 of this regulation as they apply to small employers whose coverage has been terminated by the carrier and to individuals and small employers whose coverage has been limited or restricted by the carrier.

For the purpose of paragraph (c)(2) of this section, the provisions of the Act and this regulation shall apply to the coverage issued to new entrants.

(d) Five year prohibition exclusion from market. If the filing made pursuant to paragraph (a) of this section indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state, except as provided for in paragraph (c) of this section, for a period of five years from the date of the filing. Upon a written request from a carrier, the commissioner may reduce said period provided for in the previous sentence if the commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers and their employees in the state.

Section 12 ***Annual Filing***

(a) Annual filing required. A small employer carrier shall make an annual filing with the health insurance commissioner. The filing must comply with the requirements of this section.

(b) Rates proposed to be charged or the rating formula proposed to be used.

(1) The annual filing must contain information supporting the rates proposed to be charged or a rating formula proposed to be used by the carrier in the small employer market.

(2) The rates proposed to be charged or the rating formula proposed to be used shall be based on a minimum projected loss ratio of eighty percent.

(3) Hearing.

(A) Within twenty days of the filing, the commissioner shall make a determination as to whether a hearing will be held. If the commissioner determines that there should be a hearing, the hearing will be held within sixty days after receipt of the filing, upon not less than ten days prior written notice. The hearing notice shall contain a description of the rates proposed to be charged or the rating formula proposed to be used, and a copy of the notice shall be sent to the carrier and to the department of attorney general.

(B) At the hearing, the carrier shall be required to establish that the rates proposed to be charged or the rating formula proposed to be used are consistent with the proper conduct of its business and with the interest of the public.

(C) Conduct of the hearing. The hearing shall be conducted in accordance with OHIC Regulation 6. The commissioner, or the commissioner's designee, upon that hearing may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance and require the production of all books, papers, records, correspondence, or other documents which he or she deems relevant. Any designee who shall conduct a hearing pursuant to this section shall report his or her findings in writing to the commissioner within eighty days of the filing with a recommendation for approval, disapproval, or modification of the rates proposed to be charged or the rating formula proposed to be used by the applicant. The recommended decision shall become part of the record. The commissioner shall make and issue a decision not later than ten days following the issuance of the recommended decision or, if the commissioner conducts the hearing without the appointment of a designee, as soon as is reasonably possible following the completion of the hearing. The decision may approve, disapprove, or modify the rates proposed to be charged or the rating formula proposed to be used by the carrier and may take into consideration any of this information required to be filed under this section.

(D) Carriers shall underwrite the reasonable expenses incurred by the Office in connection with the hearing, including but not limited to any costs related to advertisements, stenographic reporting, expert witnesses fees, actuarial fees and the per diem cost of the designee as appointed by the commissioner.

(E) The commissioner's designee shall mean a person who is impartial, a member in good standing of the Rhode Island bar and a person who is sufficiently acquainted with the rules of evidence as used in the superior court of the state so as to enable that person to conduct a hearing as designee of the commissioner.

(F) A carrier that is aggrieved by the commissioner's decision after a hearing may move for reconsideration by the commissioner within twenty days of the date of the decision. The commissioner shall issue a decision on the motion for reconsideration within ten days of receiving the motion. Such motions may be granted by the commissioner for the following reasons: (1) mistake, inadvertence, surprise, or excusable neglect; (2) newly discovered evidence which by due diligence could not have been discovered in time for presentation at the hearing; (3) fraud, misrepresentation, or other misconduct of an adverse party; or (4) any other reason justifying relief from the decision. A party is not required to file a motion for reconsideration prior to appeal of the decision pursuant to R.I. Gen Laws § 42-35-15. However, if a carrier files a timely motion for reconsideration, carrier will not be considered to have fully exhausted all administrative remedies until a decision has been issued by the commissioner on the motion.

(G) A carrier that is aggrieved by the commissioner's decision after exhausting all available administrative remedies is entitled to appeal the commissioner's decision in accordance with R.I. Gen. Laws § 42-35-15.

(4) No hearing is held.

(A) If no hearing is held on the filing, the commissioner shall evaluate the filing to determine if the carrier has established that the rates proposed to be charged or the rating formula proposed to be used are consistent with the proper conduct of its business and with the interest of the public. The commissioner shall make and issue a decision as soon as is reasonably possible following the filing. The decision may approve, disapprove, or modify the rates proposed to be charged or the rating formula proposed to be used by the carrier and may take into consideration any of this information required to be filed under this section. Carriers shall underwrite the reasonable expenses incurred by the Office in connection with the evaluation of the filing, including but not limited to any expert and/or actuarial fees.

(B) A carrier that is aggrieved by the commissioner's decision on a filing without a hearing may request an administrative hearing pursuant to paragraph (b)(3) of this section. A carrier will not be considered to have fully exhausted all

available administrative remedies until a decision has been issued by the commissioner after a full administrative hearing on the filing.

(c) In addition to the information required by paragraph (b) of this section, the annual filing must contain the following information related to health benefit plans issued by the carrier to small employers in this state:

(1) the number of small employers that were issued health benefit plans in the previous calendar year (separated as to newly issued plans and renewals and separated as to those that were accepted after medical underwriting and those to which no medical underwriting was applied);

(2) the number of small employers that were issued the HealthPact plan in the previous calendar year (separated as to newly issued plans and renewals);

(3) the number of small employer health benefit plans in force in each county (or by zip code) of the state as of December 31 of the previous calendar year;

(4) the number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;

(5) the number of small employer health benefit plans that were terminated or nonrenewed for reasons other than nonpayment of premium by the carrier in the previous calendar year;

(6) the number of small employer health benefit plans that were issued to small employers that were uninsured for at least the three months prior to issue;

(7) an actuarial certification as described in paragraph (d) of this section;

(8) information describing the efforts undertaken by the carrier to enhance the affordability of its products and implement policies and developments that improve the quality and efficiency of health care service delivery and outcomes in the state, as required by the commissioner; and

(9) such other information as the commissioner may require.

(d) Actuarial certification.

(1) The actuarial certification shall be made by an appointed actuary and shall certify that the carrier is in compliance with the Act and that the rating methods of the carrier are actuarially sound. The certification shall be in a form and manner, shall contain the information specified in section of the regulation and shall be signed by a qualified actuary. A copy of the certification shall be retained by the carrier at its principal place of business.

(2) Standard for actuarial certification and associated analysis.

(A) The certification shall be in the form of a written report, signed by the appointed actuary, and include such additional exhibits as may be required to support the conclusions and opinions stated in the certification. It should be prepared in accordance with Actuarial Standard of Practice No. 26 of the American Academy of Actuaries, "Compliance with Statutory and

Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans," and shall contain a statement to that effect.

(B) The certification shall include, but not be limited to, the following areas of compliance:

(i) compliance with restrictions related to premium rates in R.I. Gen. Laws § 27-50-5;

(ii) compliance with provisions related to renewability of coverage in R.I. Gen. Laws § 27-50-6;

(iii) compliance with provisions related to availability of coverage in R.I. Gen. Laws § 27-50-7; and

(iv) compliance with provisions related to certification of creditable coverage in R.I. Gen. Laws § 27-50-8.

(C) The certification shall identify any instances of non-compliance in any of the above areas, and the number of instances of each type of non-compliance, the nature of the lack of compliance and the steps taken or recommended to correct non-compliance either retroactively or prospectively.

(D) The certification shall contain a statement describing the extent, if any, to which the appointed actuary relied upon the work of others in reaching his or her conclusions. If the appointed actuary has relied upon the work of others, a statement from the person or persons relied upon describing the accuracy and completeness of the work shall be attached.

(E) The appointed actuary shall maintain copies of all work papers necessary to support the conclusions reached in the certification for a minimum period of three years after the due date of the certification, and be prepared to explain the work done and/or produce the work papers to the commissioner or his or her designee upon request.

(3) A qualified actuary is an individual who:

(A) is a member in good standing of the American Academy of Actuaries;

(B) is familiar with the requirements applicable to carriers under the Act;

(C) is qualified to sign Prescribed Statements of Actuarial Opinion regarding compliance with small employer group health laws and regulations in accordance with the American Academy of Actuaries qualifications for actuaries signing such statements;

(D) has not been found by the commissioner or his or her designee (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing to have:

(i) violated any provision of, or any obligation imposed by, Rhode Island's insurance laws or other law in the course of his or her dealings as a qualified actuary;

(ii) been found guilty of fraudulent or dishonest practices;

(iii) demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(iv) submitted to the commissioner during the past five years, pursuant to the Act, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this regulation including standards set by the Actuarial Standards Board; or

(v) resigned or been removed as an actuary within the past five years as a result of actions or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(E) has not failed to notify the commissioner of any action taken by any insurance commissioner of any other state similar to those described above.

(4) An "appointed actuary" is a qualified actuary who is appointed or retained to prepare the Statement of Actuarial Opinion required by R.I. Gen. Laws § 27-50-5(h), either directly by or by the authority of the board of directors through an executive officer of the carrier. The carrier shall give the commissioner not less than thirty days written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the carrier as an appointed actuary and shall state in such notice that the person meets the requirements set forth in this section. Once notice is furnished, no further notice is required with respect to this person, provided that the carrier shall give the commissioner not less than thirty days written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in this section. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement and that the replacement actuary meets the requirements hereof.

(e) Filing deadline. The filing described in this section shall be filed no later than March 15 of each year.

(f) Public availability of filing. Except for those documents for which a privilege is claimed or which contain proprietary information, any documents contained in the filing or presented in support of the filing under this section shall be made available for public examination at any time and place that the Commissioner may deem reasonable. The filing and the documents in support of the filing may also be posted on the Commissioner's web site. Any claim by the carrier that documents in the filing are privileged or contain proprietary information must be made at the time of the filing. In the absence of such claims, the filing and the supporting documents may be made available to the public at the time of the filing.

Section 13 ***<u>Development of Standardized Collection Tools</u>***

(a) Health status data collection tools. Standardized health status data collection tools for the purposes of obtaining information to apply the health status factor adjustment described in paragraph (b) of Section 5 of this regulation shall be developed by the health insurance commissioner in conjunction with the carriers no later than June 1, 2008.

(b) Eligible enrollee certification tools. Standardized certification tools for the purposes of complying with paragraph (c)(1) of Section 6 of this regulation shall be developed by the health insurance commissioner in conjunction with the carriers no later than June 1, 2008.

Section 14 ***<u>Wellness Health Benefit Plan—The HealthPact Plan</u>***

(a) Requirement to offer. Carriers that actively market health benefit plans to small employers in Rhode Island shall offer to those employers a wellness health benefit plan that meets the requirements of this section and complies with all other requirements of the Act and this regulation. Nothing in the Act or this regulation prohibits the sale of health benefit plans that differ from the wellness health benefit plans provided for in this section.

(b) Effective date. Unless a carrier has received a waiver from the health insurance commissioner, all carriers that actively market health benefit plans to small employers in Rhode Island shall offer a wellness health benefit plan to small employers no later than October 1, 2007.

(c) HealthPact. The wellness health benefit plan shall be referred to as the "HealthPact" plan.

(d) Requirements of the HealthPact plan.

(1) In general.

(A) The HealthPact plan shall have two levels of benefits: Advantage and Basic.

(B) Requirements for Advantage-level benefits are dependent on the member's age.

(i) Members (including dependents) who are eighteen years of age or over at the time of enrollment or renewal are classified as "adult members" and are subject to the requirements for adult members.

(ii) Members who are between the ages of twelve and seventeen years of age at the time of enrollment or renewal are considered "adolescent members" and are subject to the requirements for adolescent members.

(iii) Members who a under the age of twelve at the time of enrollment or renewal are considered "child members" and are subject to the requirements for child members.

(C) The premium rates for the Advantage-level and Basic-level plans shall be the same, with Advantage-level members paying less for medical care, including but not limited to:

(i) lower copays for physician visits;

(ii) lower coinsurance for specific procedures;

(iii) lower annual deductibles; and

(iv) lower out-of-pocket maximums.

(D) Members who do not complete the requirements for Advantage-level benefits will receive Basic-level benefits. All members of a family must complete the Advantage-level requirements specified in paragraph (d)(2) of this section in order for the family to be eligible to receive Advantage-level benefits.

(2) Different yearly requirements.

(A) Requirements for Advantage-level benefits increase on a yearly basis over a period of three years.

(B) Year-one Advantage-level benefits are tied to the following requirements:

(i) for adult members, completion of the requirements set out in paragraph (d)(3)(A) of this section no later than twenty-one days prior to enrollment;

(ii) for adolescent members, completion of the requirements set out in paragraph (d)(3)(C) of this section no later than twenty-one days prior to enrollment; and

(iii) for child members, completion of the requirements set out in paragraph (d)(3)(E) of this section no later than twenty-one days prior to enrollment.

(C) Year-two Advantage-level benefits are tied to the following requirements:

(i) for adult members, compliance with the requirements set out in paragraph (d)(3)(B) of this section no later than two hundred and forty days (eight months) from the date of enrollment;

(ii) for adolescent members, compliance with the requirements set out in paragraph (d)(3)(D) of this section no later than two hundred and forty days (eight months) from the date of enrollment; and

(iii) for child members, compliance with the requirements set out in paragraph (d)(3)(F) of this section no later than two hundred and forty days (eight months) from the date of enrollment.

(D) Year-three Advantage-level benefits will be tied to achievement of goals related to:

(i) smoking cessation, if applicable;

(ii) weight loss or weight management, if applicable;

(iii) participation in a disease management program (or programs), if applicable; and

(iv) participation in a case management program (or programs), if applicable.

Guidelines for year three Advantage-level requirements will be established by the commissioner no later than November 1, 2007.

(3) Advantage-level requirements.

(A) Each adult member must comply with specified wellness requirements for year-one Advantage-level benefits. These requirements include:

(i) selection of a primary care physician (PCP);

(ii) completion and submission of a Personal Health Assessment (PHA); and

(iii) completion and submission of a HealthPact pledge.

(B) Each adult member must comply with specified wellness requirements for year-two Advantage-level benefits. These requirements include:

(i) completion and submission of a PCP Checklist;

(ii) completion and submission of a Participation Commitment Form (PCF), which specifies participation in a smoking cessation program, if necessary, and participation in a weight loss or weight management program, if necessary;

(iii) participation in a disease management program (or programs), when identified for such a program (or programs) by the carrier; and

(iv) participation in a case management program (or programs), when identified for such a program (or programs) by the carrier.

(C) Each adolescent member must comply with specified wellness requirements for year-one Advantage-level benefits. These requirements include:

(i) selection of a PCP;

(ii) completion and submission of a PHA; and

(iii) completion and submission of a HealthPact pledge.

(D) Each adolescent member must comply with specified wellness requirements for year-two Advantage-level benefits. These requirements include:

(i) completion and submission of a PCP Checklist;

(ii) participation in smoking cessation program, if necessary, and participation in a weight loss or weight management program, if necessary (no submission of PCF);

(iii) participation in a disease management program (or programs), when identified for such a program (or programs) by the carrier; and

(iv) participation in a case management program (or programs), when identified for such a program (or programs) by the carrier.

(E) Each child member must comply with specified wellness requirements for year-one Advantage-level benefits. These requirements include:

(i) selection of a PCP; and

(ii) completion and submission of a PHA.

(F) Each child member must comply with specified wellness requirements for year-two Advantage-level benefits. These requirements include:

(i) participation in a disease management program (or programs), when identified for such a program (or programs) by the carrier; and

(ii) participation in a case management program (or programs), when identified for such a program (or programs) by the insurer.

(e) Eligibility. Determination of Advantage-level versus Basic-level eligibility will be made by the carrier. Members will only move from one level of benefits to another (e.g., Advantage to Basic) on the enrollment anniversary date.

(f) Forms and Documents.

(1) The enrollment package shall include the following forms and documents related to year-one Advantage-level eligibility:

(A) a year-one Advantage-level eligibility instruction sheet and checklist that substantially conforms to the model set out in Appendix C of this regulation;

(B) a HealthPact pledge form that substantially conforms to the model set out in Appendix D of this regulation.

(C) a form for selecting a PCP; and

(D) a PHA form.

(2) Carriers may develop and use their own PHA forms. The commissioner may, in consultation with the carriers, develop a standard PHA form for use with HealthPact plans.

(3) The forms and documents related to year-one Advantage-level eligibility shall be grouped together or otherwise conspicuously arranged so that members can readily identify all documents and forms necessary for eligibility for year-one Advantage-level benefits.

(4) The enrollment package shall include the following forms and documents related to year-two Advantage-level eligibility:

(A) a year-two Advantage-level eligibility instruction sheet and checklist that substantially conforms to the model set out in Appendix E of this regulation;

(B) PCP checklists that substantially conform to the models set out in Appendices F and G of this regulation;

(C) a sample Body Mass Index (BMI) chart that includes a statement that the sample BMI chart is for informational purposes only and that members should rely on their PCP rather than the sample BMI chart to determine their own BMI;

(D) statement that defines "smoke" or "smoking" as use of a tobacco product within the six month period prior to the completion of the PCP checklist; and

(E) an PCF that substantially conforms to the model set out in Appendix H of this regulation.

(5) The forms and documents related to year-two Advantage-level eligibility shall be grouped together or otherwise conspicuously arranged so that members can readily identify all documents and forms necessary for eligibility for year-one Advantage-level benefits.

(6) Written copies of the forms and documents required by paragraph (f) of this section shall be made available to members upon request at no charge and shall also be available on the carrier's website. Members shall also be informed that a photocopy of these form and documents may be filled out and submitted to the carrier.

(g) Rates.

(1) The commissioner shall set an average annualized individual premium rate for the HealthPact plan to be less than ten percent of the average annual statewide wage, as reported by the Rhode Island department of labor and training, in their report entitled "Quarterly Census of Rhode Island Employment and Wages." In the event that this report is no longer available, or the commissioner determines that it is no longer appropriate for the determination of maximum annualized premium, an alternative method shall be adopted by the commissioner by regulation. 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.

(2) Carriers must offer a HealthPact plan at a base community rate that is at or below the rate established pursuant to paragraph (g)(1) of this section and consistent with the requirement of Section of this regulation. Each carrier must receive approval of its annual HealthPact plan base community rate from the commissioner. Carriers may make adjustments to their HealthPact plan base community rate in accordance with the Act and Section 5 of this regulation.

(3) Carriers may increase their HealthPact plan base community rate throughout the year, but only as authorized by the commissioner.

(h) Benefits to be offered.

(1) The benefits to be provided in any HealthPact plan, by either new or renewal coverage commencing before October 1, 2008, shall be consistent with the guidance provided by the advisory committee established pursuant to R.I. Gen. Laws. § 27-50-10. This guidance is contained in the HealthPact plan requirements document, available from OHIC.

(2) The benefits to be provided in any HealthPact plan, by either new or renewal coverage commencing on or after October 1, 2008, shall be consistent with the guidance provided by the commissioner in an annual HealthPact plan requirements document. The procedures for establishing the annual plan requirements document guidance, including timeframes for the approval process, shall be specified by the commissioner in an OHIC bulletin, to be issued no later than May 1 of each year.

(i) Appeals. Carriers shall develop and consistently apply an appeal mechanism for a member dissatisfied with his or her Basic-level benefits determination. Carriers may satisfy this requirement through the use of existing appeal processes and procedures.

(j) Marketing.

(1) A small employer carrier shall actively market a HealthPact plan in accordance with R.I. Gen. Laws Section 27-50-7(b). Prior to offering a HealthPact plan, a carrier shall provide the commissioner with a copy of the carrier's initial marketing plan for its HealthPact plan.

(2) A small employer carrier may not suspend the marketing or issuance of the HealthPact plan unless the carrier has good cause and has received the prior approval of the Commissioner.

(3) Any producer authorized by a small employer carrier to market health benefit plans to small employers in this state shall also be authorized to market the HealthPact plan.

(4) Carriers are free to use any name for the marketing of the HealthPact plan; however, a tagline identifying the wellness health benefit plan as a "HealthPact" plan shall be used by the carriers in all marketing materials related to the HealthPact plan. The insurers shall be free to name the HealthPact plan in accordance with its standard product naming process and conventions. Either the tagline or the logo shall appear on the health plan identification cards for the HealthPact plan in accordance with the style guide developed by the commissioner. The style guide is available from the OHIC and is posted on the OHIC website.

(k) Dual option. The HealthPact plan must be offered on a dual option and sole replacement basis to all small group employers. "Offered" means at a minimum that every rate sheet from the insurer to a broker or a small group must include the HealthPact plan as an option. This requirement will be reevaluated in time for applications and renewals commencing no later than October 1, 2009. This dual option requirement will be reevaluated in terms of its impact on each carrier's HealthPact plan membership, loss ratio, and other relevant metrics.

(l) Enrollment cap. Carriers may set an enrollment cap of no fewer than 5,000 HealthPact plan members. Once the cap is reached in a particular year, carriers may cease to offer the HealthPact plan for the remainder of the year. The cap may be reevaluated annually by the commissioner, with the first evaluation performed in time for applications and renewals commencing no later than October 1, 2009.

(m) Time limits for participation requirements. The following timeline shall apply to all new and renewal applications for HealthPact plans:

(1) Distribution of enrollment or renewal packages. Enrollment or renewal packages containing the information, documents and forms required by this regulation for HealthPact plans shall be provided to employers, either directly by the carrier or through a broker, no later than forty-five days prior to the employer's expected enrollment or renewal date.

(2) Completion and submission of year-one Advantage level eligibility requirements.

(A) In order to meet the requirements set out in section (d)(2)(B) of this regulation, members must forward to the carrier, either by mail (first class postage) or delivery (by hand or by a third-party) the pledges, PCP selection forms and PHAs, as required by sections (d)(3)(A) (for adults), (d)(3)(C) (for adolescents), or (d)(3)(E) (for children), no later than twenty-one days prior to the enrollment date.

(B) Members will meet the deadline required by section (d)(2)(B) of this regulation if the forms, if mailed, are postmarked on or before the twenty-first day prior to the enrollment date, or if delivered, are received by the carrier before the close of business on or before the twenty-first day prior to enrollment date.

(C) If the twenty-first day prior to enrollment date falls on a weekend or state or federal holiday, the deadline shall be extended by the carrier to the next business day.

(3) Reminder card or letter. No later than one hundred and fifty days (five months) after enrollment, carriers shall send a reminder card or letter to members alerting members of the year-two Advantage-level requirements and deadlines.

(4) Completion and submission of year-two Advantage level eligibility requirements. In order to be eligible for year-two Advantage-level benefits, members must:

(A) Complete the PCP checklist no later than two hundred and ten days (seven months) after the enrollment date.

(B) Participate in case management and/or disease management programs no later than two hundred and forty days (eight months) after the enrollment date, if:

(i) selected by the carrier for case management and/or disease management programs; and

(ii) notified by the carrier of the case management and/or disease management programs no later than one hundred and eighty days (six months) after the enrollment date.

(iii) Members who are notified by the carrier of selection for case management and/or disease management programs after the deadline set out in paragraph (h)(4)(B)(ii) of this section, must nevertheless participate in the case management and/or disease management programs, however, this participation shall not affect the member's year-two Advantage-level eligibility, but shall affect the member's year-three (and subsequent) Advantage-level eligibility.

(C) Meet the requirements set out in section (d)(2)(B) of this regulation.

(1) In order to meet the requirements set out in section (d)(2)(C) of this regulation, members must forward to the carrier, either by mail (first class postage) or delivery (by hand or by a third-party) the PCP checklists and PCFs, as required by sections (d)(3)(B) (for adults), (d)(3)(D) (for adolescents), or (d)(3)(F) (for children), to the carrier no later than two hundred and forty days (eight months) after the enrollment date.

(2) Members will meet the requirements set out in section (d)(2)(C) of this regulation if the forms, if mailed, are postmarked on or before the two hundred and fortieth day after the enrollment date, or if delivered, are received by the carrier before the close of business on or before the two hundred and fortieth day after the enrollment date.

(3) If the two hundred and fortieth day after the enrollment date falls on a weekend or state or federal holiday, the deadline shall be extended by the carrier to the next business day.

An example of the Advantage-level benefits timeline for adults with an October 1, 2007 enrollment date is as follows:

Number of days to/from enrollment	Action	Date
-45	Enrollment packages received by employer	8/17/2007
-21	Last day for employees to submit: (1) PCP selection form (2) Signed pledge (3) PHA form	9/10/2007
0	Enrollment date	10/1/2007
+150	Reminder card/letter	2/28/2008

	sent by carrier for year-two Advantage-level requirements	
+180	Last day for carriers to notify subscribers of case management and/or disease management participation requirement in time to affect year-two Advantage eligibility.	3/31/2008
+180	Last day for PCP office visit to fill out PCP Checklist	4/28/2008
+240	Last day for members to participate in CM and DM, if necessary, to affect year-2 Advantage eligibility.	5/28/2008
+240	Last submission of the following to carriers: (1) PCP checklist and (2) FCF.	5/28/2008

(n) Non-renewal date enrollment. Employers may switch from an existing product to the HealthPact plan with the same carrier earlier than the employers scheduled renewal date, thereby changing their effective renewal date, at no penalty to the employer. Employers interested in purchasing the HealthPact plan but who are unable to complete the enrollment requirements within the required twenty-one days prior to their scheduled renewal date may extend their existing plan for at least thirty days (one month) in order to allow sufficient time to complete the new enrollment requirements, at no penalty to the employer.

(m) Network Requirements. The carriers shall develop a tiered network. Each carrier's tiered network structure must be implemented for all new and renewal HealthPact plan members no later than October 1, 2008. OHIC rating decisions for rates applicable to October 1, 2008 and later will assume compliance with this requirement. Draft tiered network proposals to be implemented on October 1, 2008 must be submitted to OHIC on or before September 1, 2007. A final tiered network proposal must be submitted to OHIC on or before January 1, 2008. OHIC decisions regarding carrier proposals will be determined on or before February 1, 2008. OHIC decisions regarding future revisions/phased implementation of network proposals (after October 1, 2008) will be made in response to the final carrier proposals.

(o) Bulletins. The commissioner may issue bulletins for clarification or additional guidance on the HealthPact plan. Carriers may also request guidance from the commissioner in the form of a bulletin.

(p) Late enrollees. Year-one enrollees (including added dependents) who are added to an employer's HealthPact plan after the year-one enrollment date must meet the following requirements to be eligible for year-one and year-two Advantage-level benefits:

(1) adult members must meet the requirements set out in paragraphs (d)(3)(A) of this section at the time of enrollment;

(2) adolescent members must meet the requirements set out in paragraphs (d)(3)(C) of this section at the time of enrollment; and

(3) child members must meet the requirements set out in paragraphs (d)(3)(E) of this section at the time of enrollment.

(q) Switching carriers. If an employer switches carriers after enrolling in the HealthPact plan after, the new carrier may require the employer's enrollees to meet the Advantage-level benefits requirements that would have been required of those enrollees had the employer remained enrolled in the HealthPact plan through the previous carrier.

Section 15 ***Severability***

If any provision of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected thereby.

Section 16 ***Effective Date***

This regulation shall be effective upon filing with the Secretary of State.

EFFECTIVE DATE: January 28, 2008

APPENDIX A

MODEL DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption.

APPENDIX B

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

***IMPORTANT** – This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____
2. Name of group health plan: _____
3. Name of participant: _____
4. Identification number of participant: _____
5. Name of any dependents to which this certificate applies: _____

   _____

   _____
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____

   _____

   _____
7. For further information, call: _____

   _____
8. If the individuals identified in line 3 and line 5 have at least 18 months of creditable coverage (disregarding periods of coverage before a 90-day break), check here ☐ (and skip lines 9 and 10).
9. Date waiting period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended: _____ (or check here ☐ if coverage is continuing as of the date of this certificate).

NOTE: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

APPENDIX C

INSTRUCTIONS FOR YEAR-ONE ADVANTAGE-LEVEL BENEFITS

HealthPact Plan [use standard brand format and logo]

***IMPORTANT** – In order to receive year-one Advantage-Level benefits (beginning at enrollment) in [insert product name, a HealthPact Plan], each adult (age 18 and over at the time of enrollment) must complete the following:

1. **HealthPact Pledge Form**
   Every adult must complete and submit the attached HealthPact Pledge Form twenty-one days prior to the enrollment date. The enrollment date is the date your coverage begins.

2. **Primary Care Physician (PCP) Selection Form**
   Every adult must complete and submit the attached PCP Selection Form twenty-one days prior to the enrollment date.

3. **Personal Health Assessment (PHA) Form**
   Every adult must complete and submit the attached PHA Form twenty-one days prior to the enrollment date.

In order to receive year-one Advantage-Level benefits (beginning at enrollment) in [insert product name, a HealthPact Plan], each adolescent (who is at least 12 but not older than 17 at the time of enrollment) must complete the following:

1. **HealthPact Pledge Form**
   Every adolescent must complete and submit the attached HealthPact Pledge Form twenty-one days prior to the enrollment date. The enrollment date is the date your adolescent's coverage begins.

2. **Primary Care Physician (PCP) Selection Form**
   The attached PCP Selection Form must be completed and submitted for every adolescent twenty-one days prior to the enrollment date.

3. **Personal Health Assessment (PHA) Form**
   The attached PHA Form must be completed and submitted for every adolescent twenty-one days prior to the enrollment date.

In order to receive year-one Advantage-Level benefits (beginning at enrollment) in [insert product name, a HealthPact Plan], each child (who is under 12 at the time of enrollment) must complete the following:

1. **Primary Care Physician (PCP) Selection Form**
   The attached PCP Selection Form must be completed and submitted for every adolescent twenty-one days prior to the enrollment date. The enrollment date is the date your child's coverage begins.

2. **Personal Health Assessment (PHA) Form**
   The attached PHA Form must be completed and submitted for every child twenty-one days prior to the enrollment date.

No HealthPact Pledge Form is required for children under 12.

Please use the attached checklist to ensure that all requirements have been met. Mail the checklist and all required forms to:

[insert carrier name and address]

no later than twenty-one days prior to enrollment. If we do not receive of these forms from each family member as required, the entire family shall receive Basic level benefits.

Additional forms are available at our website, at [insert web address]

Your 21 day deadlines are as follows:

If your enrollment date is:		21 days before enrollment is:
Monday, October 1, 2007	→	Monday, September 10, 2007
Thursday, November 1, 2007	→	Thursday, October 11, 2007
Saturday, December 1, 2007	→	Monday, November 12, 2007*
Tuesday, January 1, 2008	→	Tuesday, December 11, 2007
Friday, February 1, 2008	→	Friday, January 11, 2008
Saturday, March 1, 2008	→	Monday, February 11, 2008*
Tuesday, April 1, 2008	→	Tuesday, March 11, 2008
Thursday, May 1, 2008	→	Thursday, April 10, 2008
Sunday, June 1, 2008	→	Monday, May 12, 2008*
Tuesday, July 1, 2008	→	Tuesday, June 10, 2008
Friday, August 1, 2008	→	Friday, July 11, 2008
Monday, September 1, 2008	→	Monday, August 11, 2008
Wednesday, October 1, 2008	→	Wednesday, September 10, 2008

*The 21st day prior to the December, March and June dates falls on a weekend day and has therefore been advanced to the next Monday.

HealthPact Plan [use standard brand format and logo]
Year-One Advantage Benefits Checklist

List of Adults (18 and over as of the date of enrollment):

1._____
Name
- ❒ HealthPact Pledge Form completed and enclosed
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

2._____
Name
- ❒ HealthPact Pledge Form completed and enclosed
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

3._____
Name
- ❒ HealthPact Pledge Form completed and enclosed
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

4._____
Name
- ❒ HealthPact Pledge Form completed and enclosed
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

5._____
Name
- ❒ HealthPact Pledge Form completed and enclosed
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

List of Adolescents (12 to 17 as of the date of enrollment):

1._____
Name
- ❒ HealthPact Pledge Form completed and enclosed
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

2._____
Name
- ❒ HealthPact Pledge Form completed and enclosed
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

3._____
Name
- ❒ HealthPact Pledge Form completed and enclosed
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

4._____
Name
- ❒ HealthPact Pledge Form completed and enclosed
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

5._____
Name
- ❒ HealthPact Pledge Form completed and enclosed
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

List of Children (under 12 as of the date of enrollment):

1._____
Name
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

2._____
Name
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

3._____
Name
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

4._____
Name
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

5._____
Name
- ❒ PCP Selection Form completed and enclosed
- ❒ PHA Form completed and enclosed

APPENDIX D

MODEL ADVANTAGE-LEVEL BENEFITS PLEDGE

HealthPact Plan [use standard brand format and logo]
Advantage Benefits Pledge

This plan focuses on primary care, prevention, and wellness. This plan also emphasizes the importance of proper treatment for the chronically ill. To support these goals, and to obtain the Advantage level of benefits, individuals and family members must pledge to commit to the goals of the HealthPact plan, as follows:

I, _____ (print member name), agree to:

- Participate in a smoking cessation program, if currently a smoker, or remain smoke-free if a non-smoker.
- Participate in a weight loss or weight management program, if I have a high Body Mass Index (BMI), or maintain a healthy weight if my BMI is in the healthy range.
- Participate in disease management or case management, if identified by [name of carrier] as an individual who would benefit from these programs.

Today is _____, 200__, and I understand my participation in the Advantage program is dependent on my engagement in the above mentioned programs.

Signed _____
(By the member if 18 or older as of the date of enrollment or the member's parent or guardian if the member is 12 to 17 years old)

No pledge is required of members under 12 years old.

APPENDIX E

INSTRUCTIONS FOR YEAR-TWO ADVANTAGE-LEVEL BENEFITS

HealthPact Plan [use standard brand format and logo]

***IMPORTANT** – In order to retain Advantage Level benefits in Year-Two for [insert product name, a HealthPact Plan], each adult (age 18 and over at the time of enrollment) must complete the following:

1. **Primary Care Physician Checklist (PCP Checklist)**
   Every adult must have the attached PCP checklist filled out by his/her primary care physician within 180 days (six months) of enrollment. This form is intended to identify smoking cessation and weight management goals for each member.

2. **HealthPact Participation Commitment Form**
   Within 240 days (eight months) of enrollment, every adult must fill out the attached HealthPact Participation Commitment Form. This form is intended to conform each member's actions taken to comply with the wellness programs identified by his/her primary care physician in the PCP Checklist (related to smoking cessation and/or weight management).

In order to retain the Advantage Level benefits in Year-Two for [insert product name, a HealthPact Plan], each child who is at least 12 but not older than 17 at the time of enrollment must complete the following:

Primary Care Physician Checklist (PCP Checklist)
Every child must have the attached PCP checklist filled out by his/her primary care physician within 180 days (six months) of enrollment. This form is intended to identify smoking cessation and weight management goals for each member.

No HealthPact Participation Commitment Form is required for children aged 12 to 17.

No PCP Checklist or HealthPact Participation Commitment Form is required for children under 12.

Please use the attached checklist to ensure that all requirements have been met. Mail the checklist and all required forms to:

[insert carrier name and address]

no later than 240 days (eight months) after enrollment. If we do not receive of these forms from each family member as required within eight months of enrollment, the entire family shall receive Basic level benefits.

Additional forms are available at our website, at [insert web address]

Your 180 day deadlines are as follows:

If your enrollment date is:	180 days after enrollment is:
Monday, October 1, 2007	→ Monday, March 30, 2008*
Thursday, November 1, 2007	→ Tuesday, April 29, 2008
Saturday, December 1, 2007	→ Thursday, May 29, 2008
Tuesday, January 1, 2008	→ Monday, June 30, 2008*
Friday, February 1, 2008	→ Wednesday, July 30, 2008
Saturday, March 1, 2008	→ Thursday, August 28, 2008
Tuesday, April 1, 2008	→ Monday, September 29, 2008*
Thursday, May 1, 2008	→ Tuesday, October 28, 2008
Sunday, June 1, 2008	→ Friday, November 28, 2008
Tuesday, July 1, 2008	→ Monday, December 29, 2008*
Friday, August 1, 2008	→ Wednesday, January 28, 2009
Monday, September 1, 2008	→ Monday, Marchy 2, 2009*
Wednesday, October 1, 2008	→ Monday, March 30, 2009

*The 180th day after the October, January, April, July, and September enrollment dates falls on a weekend day and has therefore been advanced to the next Monday.

Your 240 day deadlines are as follows:

If your enrollment date is:	180 days after enrollment is:
Monday, October 1, 2007	→ Wednesday, May 28, 2008
Thursday, November 1, 2007	→ Monday, June 30, 2008*
Saturday, December 1, 2007	→ Monday, July 28, 2008
Tuesday, January 1, 2008	→ Thursday, August 28, 2008
Friday, February 1, 2008	→ Monday, September 29, 2008*
Saturday, March 1, 2008	→ Monday, October 27, 2008
Tuesday, April 1, 2008	→ Thursday, November 27,

		2008
Thursday, May 1, 2008	→	Monday, December 29, 2008*
Sunday, June 1, 2008	→	Tuesday, January 27, 2009
Tuesday, July 1, 2008	→	Thursday, February 26, 2009
Friday, August 1, 2008	→	Monday, March 30, 2009*
Monday, September 1, 2008	→	Wednesday, April 29, 2009
Wednesday, October 1, 2008	→	Friday, May 29, 2009

*The 240th day after the November, February, May, and August enrollment dates falls on a weekend day and has therefore been advanced to the next Monday.

HealthPact Plan [use standard brand format and logo] Advantage Benefits Checklist

List of Adults (18 and over as of the date of enrollment):

1._____
Name
❒ PCP Checklist completed and enclosed
❒ HealthPact Participation Commitment Form completed and enclosed

2._____
Name
❒ PCP Checklist completed and enclosed
❒ HealthPact Participation Commitment Form completed and enclosed

3._____
Name
❒ PCP Checklist completed and enclosed
❒ HealthPact Participation Commitment Form completed and enclosed

4._____
Name
❒ PCP Checklist completed and enclosed
❒ HealthPact Participation Commitment Form completed and enclosed

5._____
Name
❒ PCP Checklist completed and enclosed
❒ HealthPact Participation Commitment Form completed and enclosed

List of Adolescents (12 to 17 as of the date of enrollment):

1._____
Name
❒ PCP Checklist Completed and enclosed

2._____
Name
❒ PCP Checklist Completed and enclosed

3._____
Name
❒ PCP Checklist Completed and enclosed

4._____
Name
❒ PCP Checklist Completed and enclosed

5._____
Name
❒ PCP Checklist Completed and enclosed

APPENDIX F

PRIMARY CARE PHYSICIAN CHECKLIST FOR ADULTS (OVER 18 AT THE TIME OF ENROLLMENT)

HealthPact Plan [use standard brand format and logo]
Primary Care Physician Checklist for Adults

***IMPORTANT** – In order to receive Advantage Level benefits in [insert product name, a HealthPact Plan], this form must be completed by your primary care physician (PCP) for each adult (age 18 and over at the time of enrollment) HealthPact member and mailed by the member to:

[insert carrier name and address]

no later than eight months (240 days) after enrollment. If we do not receive of these forms for all adult family member within 240 days of enrollment, the entire family shall receive Basic level benefits.

1. Member Name: _____
2. Address _____
3. Member Identification Number: _____
4. Date of Birth: _____
5. Date of examination: _____

Body Mass Index

6. Body Mass Index (BMI) calculation
   a. Weight: _____
   b. Height: _____
   c. BMI: _____
7. The member's BMI is above his/her recommended BMI level: Yes ☐ No ☐
8. If the member's BMI is above the recommended level, has the physician discussed a weight loss program or goal with the member? Yes ☐ No ☐ (leave blank if member's BMI is not above recommended level).
9. Briefly describe the program or goal: _____
   _____
   _____
   _____
10. Additional comments: _____
    _____
    _____

Smoking

11. Is the member a smoker (has he or she smoked within the last 6 months): Yes ☐ No ☐
12. If the member is a smoker, has the physician discussed a smoking cessation program or goal with the member? Yes ☐ No ☐ (leave blank if member is not a smoker).
13. Briefly describe the program or goal: _____

14. Additional comments: _____

Physician Signature (Required)

The information supplied above is complete and accurate to the best of my knowledge.

Physician Signature: _____ Date: _____
Physician Name (printed):_____

Member Signature (Required)

I have reviewed and discussed the information supplied above with my physician and I agree to comply with his/her recommendations. I understand that submission of this PCP Checklist is required in order to continue in the Advantage level of benefits under my HealthPact plan. I further understand that I am required to submit a Participation Commitment Form documenting my compliance with my physicians' recommendations.

Member Signature: _____ Date: _____

APPENDIX G

PRIMARY CARE PHYSICIAN CHECKLIST FOR ADOLESCENTS (12-17 AT THE TIME OF ENROLLMENT)

HealthPact Plan [use standard brand format and logo]
Primary Care Physician Checklist for Children

***IMPORTANT** – In order to retain Advantage Level Year-Two benefits in [insert product name, a HealthPact Plan], this form must be completed by your adolescent's primary care physician (PCP) for each adolescent (ages 12 to17 at the time of enrollment) HealthPact member and mailed by the member to:

[insert carrier name and address]

no later than 240 days (eight months) after enrollment. If we do not receive of these forms for all 12 to 17 year old family member within 240 days of enrollment, the entire family shall receive Basic level benefits.

1. Member Name: _____
2. Address _____
3. Member Identification Number: _____
4. Date of Birth: _____
5. Date of examination: _____

Body Mass Index

6. Body Mass Index (BMI) calculation
   a. Weight: _____
   b. Height: _____
   c. BMI: _____
7. The member's BMI is above his/her recommended BMI level: Yes ☐ No ☐
8. If the member's BMI is above the recommended level, has the physician discussed a weight loss program or goal with the member and the member's parent or guardian? Yes ☐ No ☐ (leave blank if member's BMI is not above recommended level).
9. Briefly describe the program or goal: _____
   _____
   _____
   _____
10. Additional comments: _____
    _____
    _____

Smoking

11. Is the member a smoker (has he or she smoked within the last 6 months): Yes ☐ No ☐
12. If the member is a smoker, has the physician discussed a smoking cessation program or goal with the member and the member's parent or guardian? Yes ☐ No ☐ (leave blank if member is not a smoker).

13. Briefly describe the program or goal: _____

_____

_____

_____

14. Additional comments: _____

_____

_____

Physician Signature (Required)

The information supplied above is complete and accurate to the best of my knowledge.

Physician Signature: _____ Date: _____

Physician Name (printed):_____

Member Signature (Required) (To be signed by Parent or Guardian)

I have reviewed and discussed the information supplied above with my adolescent's physician and I agree to comply with his/her recommendations. I understand that submission of this PCP Checklist is required in order to continue in the Advantage level of benefits under my HealthPact plan.

Member Signature: _____ Date: _____

APPENDIX I

PARTICIPATION COMMITMENT FORM

HealthPact Plan [use standard brand format and logo] Participation Commitment Form

***IMPORTANT** – In order to receive Advantage Level benefits in [insert product name, a HealthPact Plan], this form must be completed and mailed to:

[insert carrier name and address]

no later than 240 days (eight months) after enrollment. If we do not receive of these forms for all adult family member within 240 days of enrollment, the entire family shall receive Basic level benefits.

1. Member Name: _____
2. Address _____
3. Member Identification Number: _____
4. Date of Birth: _____

To qualify for the Advantage Level Benefits you must confirm your participation in a wellness program(s). Please fill in the appropriate information.

1. Smoker/Tobacco User

☐ Yes

I, _____ (member name), confirm that I am participating in a smoking/tobacco cessation program. Today is _____, 200__, and I understand my participation in the Advantage program is dependent on my engagement in the above mentioned program(s).

Actions Taken:

_____

_____

_____

_____

_____

_____

Signed _____(member signature)

2. Smoker/Tobacco User

☐ No

I, _____ (member name), confirm that I currently am not a smoker, yet I understand that if I start smoking/using tobacco I will participate in a smoking/tobacco cessation program. Today is _____, 200__, and I understand my

participation in the Advantage program is dependent on my compliance with this statement.

Signed _____(member signature)

3. Weight Management

❒ Yes, my PCP recommended (on my PCP checklist) that I participate in a weight management program.

I, _____(member name), confirm that I am participating in the applicable weight management program(s) as directed by my PCP. Today is _____, 200__, and I understand my participation in the Advantage program is dependent on my engagement in the above mentioned program.

Actions Taken:

_____

_____

_____

Signed _____(member signature)

4. Weight Management

❒ No, my PCP did not recommend that I participate in a weight management program.

I, _____(member name), confirm that I maintain a healthy weight, according to my PCP. Today is _____, 200__, and I understand my continued participation in the Advantage program is dependent on compliance with this statement.

Signed _____(member signature)

Attachment H

Proposed Small/Large Group Rate Filing Template

Historical Information

Experience Period for Developing Rates

From	To

Utilization/Experience Data by Quarter
(Last 12 available quarters)

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Cost Containment Expense*
1 (oldest)												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses

If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Prospective Information

Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx
Total					
Price Only					
Utilization					
Other *					
Other *					
Other *					

* All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Medical Loss Ratio	Expected Contribution to Reserves	Cost Containment Expense %*	Other Claim Adjustment Expense%*	General Administrative Expense %*	Average Commissions%*	Investment Income Credit %
1									
2									
3									
4									

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses
The sum of the expenses, commissions, contributions to reserves, investment income credit and the medical loss ratio should be 100%.

Attachment I

§ 38-1-1 Delivery of records on leaving public office. – Every person who shall hold a public office shall, upon leaving the office, deliver to his or her successor in office, or, if there is no successor, to the public records administration program of the office of secretary of state, all records, books, writings, letters, and documents, kept or received by him or her in the transaction of his or her official business, and to the director of the department of administration all money in his or her hands which he or she shall have received as trust funds from any person or otherwise in the course of his or her official business; and every person who shall, without just cause, refuse or neglect for the space of ten (10) days after request made in writing by any citizen of the state, to deliver as herein required those records, books, writings, letters, or documents, or to pay over those moneys, to the person authorized to receive the requested items, shall be fined not exceeding five hundred dollars ($500) and be imprisoned not exceeding five (5) years.

§ 38-1-1.1 Definitions. – For the purpose of this chapter:

(a) "Agency" or "public body" shall mean any executive, legislative, judicial, regulatory, administrative body of the state, or any political subdivision thereof; including, but not limited to, any department, division, agency, commission, board, office, bureau, authority, any school, fire, or water district, or other agency of Rhode Island state or local government which exercises governmental functions, or any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency.

(b) "Public business" means any matter over which the public body has supervision, control, jurisdiction, or advisory power.

(c) "Public record" or "public records" shall mean all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, or other material regardless of physical form or characteristics made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency.

(d) "Supervisor of the regulatory body" means the chief or head of a section having enforcement responsibility for a particular statute or set of rules and regulations within a regulatory agency.

Office of the Health Insurance Commissioner
Health Insurer Rate Factor Review
Public Comment Solicitation: May 21, 2010

Summary:

Rising health care costs affect all of us. The Office of the Health Insurance Commissioner (OHIC) is soliciting public comment on the proposed rate factors to be used by United HealthCare of New England (UHCNE) and Blue Cross and Blue Shield of Rhode Island (BCBSRI) in calculating insurance premiums in 2010 for their large employer (>50 employees) and small employer products (50 or fewer).

This document describes the rate review process, the decision criteria and information available for public comment. Oral and written public comment is being collected through June 11, 2010.

Public input in this process is important.

I. Process and Standards

What are the goals of this Rate Factor Review Process?

1. To keep health insurance pricing fair
   - Purchasers of health insurance should pay the estimated costs of their products and not bear the burden or benefit of other lines of business.

2. More Public Accountability of Health Plans
   - Under Rhode Island Statute, health insurers are accountable for remaining financially solvent, protecting consumers, treating providers fairly, and making efforts to improve the affordability, quality and accessibility of the health care system. A publicly accessible rate review process helps hold insurers accountable for these sometimes-conflicting goals.

3. Public Education
   - Stakeholders in the system do not always understand what drives the affordability of health insurance. Increased transparency can help people make informed choices.

What Health Insurance Markets are Covered by this Process?

- This process addresses rate oversight for businesses who buy health insurance, including:

i. "Small Groups" (50 or fewer employees) - there are about 90,000 enrollees in this market.

ii. "Large Groups" (51 or more employees) – about 350,000 enrollees.

- Self Insured Groups (240,000 enrollees) are exempt from state-based regulation.

Does this process set the specific rates that businesses pay?

- No. The process allows OHIC to approve, reject or modify the "inflation factors" that insurers use to calculate the rates that are paid. Once these rate components are determined, insurers use rating formulas to set an employer-specific year long, fixed rate based on that employer's benefit plan, demographic mix and (for larger business) past claims experience.
- OHIC separately reviews the plans' rating formulas to ensure they are fair, and are consistently applied.

What will OHIC do during the public comment period?

- Publish the proposed rate factors and collect public comment.
- Conduct actuarial analysis and other review as needed.
- Review the factors with its Health Insurance Advisory Council (as established under OHIC statute)
- At its discretion, hold public meetings and/or formal hearings.

What does OHIC consider when reviewing rate factors?

- By statute, OHIC has to balance competing needs between consumers who want affordable health insurance and financially sound insurers, providers who want good payments, and insurers who need surpluses and profits to stay in business. Meeting all these needs completely is not possible.

- In striking this balance OHIC considers projected rates of increase in an insurer's medical expenses, administrative costs and profits. It is important to note that medical expenses make up 80 to 85% of the insurance premium and typically are increasing at 5-10 times general inflation. Efforts to control these increases – by public or private efforts – often are not well received. These challenges exist across the country and by the public as well as private sector. There is no single solution.

- Attachment two of the document lists the specific standards OHIC uses when considering rate increases.

Once acted upon, when would revised rating factors go into effect and for how long?

The health plans have asked for the new rate factors to be effective for Small and Large Groups for all contracts starting or renewing between January 1, 2011 and December 31, 2011.

Didn't the health plans just have rate factors approved? Why are they back for more so soon?

Rate factors were approved in March for contracts starting or renewing between July 1, 2010 and December 31, 2010. The submissions being evaluated here are for the next calendar year.

II. Summary of Rate Factors Submitted by Health Plans

OHIC attempts to analyze and make public information about health insurance cost drivers to promote better policy making and increased transparency, insurer competition, provider accountability and public awareness. Readers are encouraged to study these documents carefully. Health Insurance Premiums are increasing at 7-8 times general inflation. These help explain why.

Attachments three and four are rate factor templates for both plans. These break out insurance premiums into five medical service categories plus projected administrative costs and profits/surplus. They give the plans' estimates for the effects of price increases and utilization increases in each medical service category, plus the projected percentage of premium devoted to administrative costs and profit/surplus and the resulting overall estimated average increase in commercial health insurance premiums. (An employer will experience something different from the

average because of changes in employee demographics and utilization experience.) These attachments help compare and contrast these estimates between the plans.

III: Additional information

Available at www.ohic.ri.gov are the guidance given to the health plans for this rate filing, non-proprietary information submitted as part of the filing and more analysis by OHIC.

IV. Public Input in this Process is Important

- Rising health insurance costs are a state and national concern. The reasons are complex but this rate review is an important opportunity to balance competing concerns. Your input is important.
- OHIC is soliciting public comment from interested parties to help inform its rulings on these factors. This solicitation will be distributed via email, posted on the www.ohic.ri.gov and advertised publicly.
- While any comments are welcome, OHIC is particularly interested in recommendations regarding:
  i. Particular rate factors based on the standards identified in this document.
  ii. Assessment of health plan performance in areas of "General Conduct" and "Efforts to Improve Affordability " as defined in Attachment 1.
  iii. Any possible conditions or comments to be attached to a decision. In particular, OHIC's Health Insurance Advisory Council has issued "Affordability Priorities and Standards for Commercial Health Insurers"[4] which sets forth four priority areas of work for health plans to improve health insurance affordability:
  1. Health plans will increase the proportion of their medical expenses spent on primary care by five percentage points over the next five years. This money is to be an investment in improved capacity and care coordination, rather than a simple shift in fee schedules.
  2. As part of the increased primary care spend, health plans will promote the expansion of the CSI-Rhode Island project or an alternative all payer medical home model with a chronic care focus by at least 25 physicians in the coming year
  3. Health plans will promote Electronic Medical Records incentive programs that meet or exceed a minimum value.
  4. Health plans commit to participation in a broader payment reform initiative as convened by public officials in the future.
  The public is invited to comment on the performance of insurers in these areas and to suggest future direction by the Office.

- Oral public comment will be taken at the May 25, 2010 meeting of the Health Insurance Advisory Council at 4:30 pm Landmark Hospital in Woonsocket, RI and possibly in other subsequent settings.
- Written public comments should be submitted by February 22, 2010 via either:
  i. email to healthinsinquiry@ohic.ri.gov (preferred) or
  ii. OHIC
  1511 Pontiac Ave. Building 69-1
  Cranston, RI 02920
- All communications regarding public comments will be considered public documents.

Attachments:

Regulatory Standards for Health Plan Conduct and Standards for Health Plan Rate Factor Review
Rate factor review template for submitting health plans for large and small group markets

[4] See http://www.ohic.ri.gov/Committees_HealthInsuranceAdvisoryCouncil_Affordability%20Report.php

Attachment 1: Regulatory Standards for Plan Conduct.
(Summary of OHIC Regulation 2)[5]

I. **General Conduct** by insurers to be taken into consideration in reviewing the projected trend factors includes but are not limited to:

1. Efforts by health insurers to develop benefit design and payment policies that:
    a. Enhance the *affordability* of products (defined below)
    b. Encourage more efficient use of existing resources.
    c. Promote appropriate and cost effective acquisition of health care technology and expansion of existing infrastructure.
    d. Advance development and use of high quality health care centers.
    e. Prioritize use of limited resources.
2. 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.
3. Efforts by health insurers to promote collaboration among the state's health insurers to promote standardization of administrative practices and policy priorities.
4. 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.
5. Participating in the development and implementation of public policy issues related to health.
6. The interests of the state's health insurance consumers, including:
    a. efforts by the health insurer to ensure that consumers are able to read and understand the terms and scope of the health insurance coverage documents issued or provided by the health insurer and make fully informed choices about the health insurance coverage provided by the health insurer;
    b. the effectiveness of the health insurer's consumer appeal and complaint procedures;
    c. the efforts by the health insurer to ensure that consumers have ready access to claims information;
    d. efforts by the health insurer to increase the effectiveness of its communications with its insureds, including, but not limited to, communications related to the insureds' financial responsibilities;
    e. ensuring that that the benefits in health insurance coverage documents issued or provided by a health insurer are consistent with state laws; ensuring 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
    f. that the insurer takes steps to enhance the affordability of its products.
7. The interests of the state's health care providers, including:
    a. that the policies, procedures and practices employed by health insurers with respect to provider reimbursement, claims processing, dispute resolution, and contracting processes are understandable and transparent; and
    b. that the efforts undertaken to enhance communications with providers.

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[5] Full regulation at: http://www.ohic.ri.gov/Regulation2OHICPurposes.php

OHIC
Regulatory Standards for Plan Conduct. (Summary of OHIC Regulation 2) Cont'd

II. Evaluation of Insurer's **Efforts to Improve Affordability** of Health Insurance

1. Whether the health insurer offers a spectrum of product choices to meet consumer needs;
2. 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; and
    d. Promoting use of evidence based, quality care;
3. Whether the insurer employs provider payment strategies to enhance cost effective utilization of appropriate services;
4. Whether the insurer supports product offerings with simple and cost effective administrative processes for providers and consumers;
5. 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
6. Whether the insurer allows for an appropriate contribution to surplus.

Attachment 2

Rate factors health plans submit for approval and standards to consider

As set out in statute, OHIC must determine whether the proposed rates or rating formulas are "consistent with the proper conduct of [the insurer's] business and with the interest of the public". OHIC has defined this standard further, based on statute (RI General Laws: 42-14.5-2) in its Regulation 2.[6] (http://www.ohic.ri.gov/Regulation2OHICPurposes.php)

Rating Factor	Standards for OHIC to Consider [7]
Contributions to Reserves (%)	• Existing reserves relative to OHIC determined reserve levels (see http://www.ohic.ri.gov/2006ReservesStudy.php and http://www.dbr.state.ri.us/divisions/insurance/financial.php) • Industry averages (see http://www.ohic.ri.gov/070717healthriinsurersreport.php) • Historical performance of plan relative to budget • Return to shareholders (if appropriate) • General conduct of health plans (defined in Reg 2)
Admin Costs *(as % of total revenue)*	• Other health plans for comparable products. (see http://www.ohic.ri.gov/070717healthriinsurersreport.php) • Other commercial products from same insurer • Compliance with NAIC categorization of costs • Affordability efforts (defined in Reg 2) • General conduct (defined in Reg 2)
Trend factors *(% annual projected change in utilization and costs for five medical service categories)*	• Actuarial soundness • Other health plans in market, based on public submission • Commercial industry standards • Governmental Health Care Programs (i.e. Medicare and RIte Care) • Affordability Efforts (as defined in Reg 2) • Alignment of the affordability report with "Affordability Priorities and Standards" document from OHIC's Health Insurance Advisory Council.

[6] Summarized as Attachment 1

[7] Citations given are illustrative but not exhaustive.

Attachment K

Office of the Health Insurance Commissioner

2011 Health Plan Rate Factor Review Template: Submissions for Small Group

	Blue Cross and Blue Shield of RI						UnitedHealthCare of NE						Tufts Health Plans					
	2009 req.	2009 apprvd	2010 req.	2010 apprvd	2011 req	2011 apprvd	2009 req.	2009 apprvd	2010 req.	2010 apprvd	2011 req	2011 apprvd	2009 req.	2009 apprvd	2010 req.	2010 apprvd	2011 req	2011 apprvd
Category: Hospital Inpatient																		
Annual Rate of Price Inflation (%)	8.5		7.9		7.3		10.0		10.0		8.4		7.4	7.4	7.5	7.5	7.6	
Annual Rate of Utilization Inflation (%)	1.0		1.0		1.0		4.9		3.9		2.3		1.3	1.3	3.5	3.5	4.3	
Composite Inflation Rate %	9.6		9.0	7.5	8.4		15.5		14.3	10.0	10.9		8.8	8.8	11.2	11.2	12.2	
Category: Hospital Outpatient																		
Annual Rate of Price Inflation (%)	7.9		7.4		6.8		7.8		7.8		6.8		7.5	7.5	7.1	7.1	7.2	
Annual Rate of Utilization Inflation (%)	5.3		5.2		5.2		4.7		3.7		6.3		4.2	4.2	3.8	3.8	3.8	
Composite Inflation Rate %	13.6		13.0	9.9	12.4		12.9		11.8	10.7	13.5		12.0	12.0	11.1	11.1	11.2	
Category: Pharmacy																		
Annual Rate of Price Inflation (%)	--						4.8		4.8		5.4		7.3	7.3	5.7	5.7	6.6	
Annual Rate of Utilization Inflation (%)	--		--		-		5.8		4.9		4.8		2.6	2.6	3.1	3.1	2.3	
Composite Inflation Rate %	11.5		11.0	11.0	10.6		11.0		9.9	9.9	10.5		10.1	10.1	9.0	9.0	9.1	
Category: Primary Care																		
Annual Rate of Price Inflation (%)	19.3		15.0		8.1		3.8		3.8		4.7		6.7	6.7	6.2	6.2	5.9	

Annual Rate of Utilization Inflation (%)	3.5		3.7		4.9		5.9		5.0		5.8		1.3	1.3	4.0	4.0	3.0	
Composite Inflation Rate %	23.5		19.3	19.3	13.4		10.1		9.0	19.3	10.8		8.1	8.1	10.5	10.5	9.0	
Category: All Other Medical Care																		
Annual Rate of Price Inflation (%)	3.0		2.3		2.6		3.8		3.8		4.7		5.8	5.8	3.9	3.9	3.4	
Annual Rate of Utilization Inflation (%)	3.5		3.7		4.9		5.9		5.0		5.8		2.7	2.7	4.2	4.2	5.0	
Composite Inflation Rate (%)	6.6		6.1	6.1	7.7		10.1		9.0	7.6	10.8		8.7	8.7	8.3	8.3	8.6	
Projected Portion of Premium for Administrative Costs	17.6		14.2	14.0	13.5		17.4		16.9	16.9	12.7		13.0	12.0	13.0	13.0	14.3	
Projected Portion of Premium for Reserves and Profit	2.3		2.3	2.0	3.0		1.0		1.0	1.0	1.9		-	-	-	-	-	
Overall avg. premium increase (OHIC estimated)	13.9		11.4	9.8	12.4		13.2		10.6	6.3	15.5		9.7	8.5	9.5	9.5	12.2	

Notes:

1. Annual rate of utilization inflation also includes amounts if identified separately for mix of services, demographic change and benefit leveraging.
2. United has shown separate expenses and contribution to reserve for UHIC and UHNE. The chart shows the UHIC #s. UHNE admin is 15.9%, contribution to reserves -1.3%.
3. United target loss ratio is 82.7%. Projecting 85.4% because of inadequate rate in effect at 1/1/2011.
4. Blue Cross analyzes trend on a combined basis for small and large group; United's is separate.
5. Tufts is projecting higher commissions based on size of group and graded scale
6. Tufts has relatively higher rate increases in first six months because of catch up on health assessments.
7. Tufts reports separately for TAHMO and Tufts Ins Co. ; average rate increase is a weighted average of the two
8. Average premium increase is the average of rate increases identified by the carriers for the four quarters of 2011

Office of the Health Insurance Commissioner

2011 Health Plan Rate Factor Review Template: Submissions for Large Group

	Blue Cross and Blue Shield of RI						UnitedHealthCare of NE						Tufts Health Plans					
	2009 req.	2009 apprvd	2010 req.	2010 apprvd	2011 req	2011 apprvd	2009 req.	2009 apprvd	2010 req.	2010 apprvd	2011 req	2011 apprvd	2009 req.	2009 apprvd	2010 req.	2010 apprvd	2011 req	2011 apprvd
Category: Hospital Inpatient																		
Annual Rate of Price Inflation (%)	8.5		7.9		7.3		10.0		10.0		8.4		7.4	7.4	7.5	7.5	7.6	
Annual Rate of Utilization Inflation (%)	1.0		1.0		1.0		5.6		4.6		3.5		1.3	1.3	3.5	3.5	4.3	
Composite Inflation Rate (%)	9.6		9.0	7.5	8.4		16.3		15.1	9.5	12.2		8.8	8.8	11.2	11.2	12.2	
Category: Hospital Outpatient																		
Annual Rate of Price Inflation (%)	7.8		7.4		6.8		7.8		7.8		6.8		7.5	7.5	7.1	7.1	7.2	
Annual Rate of Utilization Inflation (%)	5.3		5.2		5.2		5.5		4.5		7.5		4.2	4.2	3.8	3.8	3.8	
Composite Inflation Rate (%)	13.6		13.0	9.9	12.4		13.8		12.6	10.5	14.8		12.0	12.0	11.1	11.1	11.2	
Pharmacy																		
Annual Rate of Price Inflation (%)	--						4.8		4.8		5.4		7.3	7.3	5.7	5.7	6.6	
Annual Rate of Utilization Inflation (%)	--		--		-		6.6		5.7		5.7		2.6	2.6	3.1	3.1	2.3	
Composite Inflation Rate (%)	10.8		11.0	11.0	10.1		11.9		10.8	10.8	11.4		10.1	10.1	9.0	9.0	9.1	
Category: Primary Care																		
Annual Rate of Price Inflation (%)	19.3		15.0		8.1		3.8		3.8		4.7		6.7	6.7	6.2	6.2	5.9	
Annual Rate of Utilization Inflation (%)	3.5		3.7		4.9		6.7		5.8		7.1		1.3	1.3	4.0	4.0	3.0	
Composite Inflation Rate (%)	23.5		19.3	19.3	13.4		10.9		9.8	19.3	12.1		8.1	8.1	10.5	10.5	9.0	

Category: All Other Medical Care																		
Annual Rate of Price Inflation (%)	3.0		2.3		2.6		3.8		3.8		4.7		5.8	5.8	3.9	3.9	3.4	
Annual Rate of Utilization Inflation (%)	3.5		3.7		4.9		6.7		5.8		7.1		2.7	2.7	4.2	4.2	5.0	
Composite Inflation Rate (%)	6.6		6.1	6.1	7.7		10.9		9.8	7.6	12.1		8.7	8.7	8.3	8.3	8.6	
Projected Portion of Premium for Administrative Costs	15.1		12.2	12.0	11.5		15.9		15.9	15.9	12.0		13.0	12.0	13.0	13.0	13.8	
Projected Portion of Premium for Reserves and Profit	3.3		2.3	2.0	3.0		1.0		1.0	1.0	5.0		-	-	-	-	-	
Overall avg. premium increase (OHIC estimated)	16.3		14.6	9.9	13.4		11.6		11.5	6.0	11.7		9.7	8.5	9.3	9.3	11.6	

Notes:

1. Annual rate of utilization inflation also includes amounts if identified separately for mix of services, demographic change and benefit leveraging.
2. United has shown separate expenses and contribution to reserve for UHIC and UHNE. The chart shows the UHIC #s. UHNE admin is 16.0%, contribution to reserves 1.0%
3. United notes that the average increase for large group is the increase in base rates only, and that actual results will vary because of demographics or plan experience.
4. Blue Cross analyzes trend on a combined basis for small and large group; United's is separate.
5. Tufts is projecting higher commissions based on size of group and graded scale
6. Tufts has relatively higher rate increases in first six months because of catch up on health assessments.
7. Tufts reports separately for TAHMO and Tufts Ins Co. ; average rate increase is a weighted average of the two
8. Average premium increase is the average of rate increases identified by the carriers for the four quarters of 2011

Attachment 4-L

§ 42-14-10 Actuary. – The administrator of banking and insurance may appoint an actuary to assist him or her in the performance of his or her duties, including, but not limited to, evaluating fire, casualty and other insurance rates. The actuary shall serve under the direction of the administrator and shall be removable at the pleasure of the administrator. Insurance companies doing business in this state shall be assessed according to a schedule of their direct writings of insurance in this state to pay for the compensation of the actuary.

Office of the Health Insurance Commissioner

2010 Health Plan Rate Factor Review Template: Submissions for Large Group

	Blue Cross and Blue Shield of RI					UnitedHealthCare of NE					Tufts Health Plans					
	2008 req.	2008 apprvd	2009 req.	2010 req.	2010 appvd	2008 req.	2008 apprvd	2009 req.	2010 req.	2010 apprvd	2008 req.	2008 apprvd	2009 req.	2009 apprvd	2010 req	2010 apprvd
Category: Hospital Inpatient																
Annual Rate of Price Inflation (%)	6.4	5.8	8.5	7.9		8.8	8.8	10.0	10.0		N/A	N/A	7.4	7.4	7.5	7.5
Annual Rate of Utilization Inflation (%)	3.0	3.0	1.0	1.0		5.3	5.3	5.6	4.6		N/A	N/A	1.3	1.3	3.5	3.5
Composite Inflation Rate (%)	9.6	9.0	9.6	9.0	7.5	14.8	12.0	16.3	15.1	9.5	N/A	N/A	8.8	8.8	11.2	11.2
Category: Hospital Outpatient																
Annual Rate of Price Inflation (%)	6.4	5.8	7.8	7.4		5.1	5.1	7.8	7.8		N/A	N/A	7.5	7.5	7.1	7.1
Annual Rate of Utilization Inflation (%)	1.9	1.9	5.3	5.2		4.3	4.3	5.5	4.5		N/A	N/A	4.2	4.2	3.8	3.8
Composite Inflation Rate (%)	8.4	7.9	13.6	13.0	9.9	9.8	9.3	13.8	12.6	10.5	N/A	N/A	12.0	12.0	11.1	11.1
Pharmacy																
Annual Rate of Price Inflation (%)	--	--	--			--	--	4.8	4.8		N/A	N/A	7.3	7.3	5.7	5.7
Annual Rate of Utilization Inflation (%)	--	--	--	--		--	--	6.6	5.7		N/A	N/A	2.6	2.6	3.1	3.1
Composite Inflation Rate (%)	10.5	10.5	10.8	11.0	11.0	12.5	12.5	11.9	10.8	10.8	N/A	N/A	10.1	10.1	9.0	9.0
Category: Primary Care																

Annual Rate of Price Inflation (%)	N/A	N/A	19.3	15.0		N/A	N/A	3.8	3.8		N/A	N/A	6.7	6.7	6.2	6.2
Annual Rate of Utilization Inflation (%)	N/A	N/A	3.5	3.7		N/A	N/A	6.7	5.8		N/A	N/A	1.3	1.3	4.0	4.0
Composite Inflation Rate (%)	N/A	N/A	23.5	19.3	19.3	N/A	N/A	10.9	9.8	19.3	N/A	N/A	8.1	8.1	10.5	10.5
Category: All Other Medical Care																
Annual Rate of Price Inflation (%)	4.0	4.0	3.0	2.3		1.8	1.8	3.8	3.8		N/A	N/A	5.8	5.8	3.9	3.9
Annual Rate of Utilization Inflation (%)	5.0	5.0	3.5	3.7		5.9	5.9	6.7	5.8		N/A	N/A	2.7	2.7	4.2	4.2
Composite Inflation Rate (%)	9.2	9.2	6.6	6.1	6.1	7.9	7.9	10.9	9.8	7.6	N/A	N/A	8.7	8.7	8.3	8.3
Projected Portion of Premium for Administrative Costs	11.5	11.5	15.1	12.2	12.0	17.7	17.7	15.9	15.9	15.9	N/A	N/A	13.0	12.0	13.0	13.0
Projected Portion of Premium for Reserves and Profit	2.4	1.4	3.3	2.3	2.0	3.2	1.0	1.0	1.0	1.0	N/A	N/A	-	-	-	-
Overall avg. premium increase (OHIC estimated)	9.3	7.8	16.3	14.6	9.9	11.0	8.0	11.6	11.5	6.0	N/A	N/A	9.7	8.5	9.3	9.3

Notes:

1. Annual rate of utilization inflation also includes amounts if identified separately for mix of services, demographic change and benefit leveraging.
2. United has projected a lower rate of medical inflation for periods after July 1, 2010 rates
3. Average premium increase is the average of rate increases identified by the carriers for July 1, 2010 renewals and October 1, 2010 renewals
4. Blue Cross analyzes trend on a combined basis for small and large group; United's is separate.
5. United notes that the average increase for large group is the increase in base rates only, and that actual results will vary because of demographics or plan experience.

Updated 2/26/10

Office of the Health Insurance Commissioner

2010 Health Plan Rate Factor Review Template: Submissions for Small Group

	Blue Cross and Blue Shield of RI					UnitedHealthCare of NE					Tufts Health Plans					
	2008 req.	2008 apprvd	2009 req.	2010 req	2010 apprvd	2008 req.	2008 apprvd	2009 req.	2010 req	2010 apprvd	2008 req.	2008 apprvd	2009 req.	2009 apprvd	2010 req	2010 apprvd
Category: Hospital Inpatient																
Annual Rate of Price Inflation (%)	5.8	5.8	8.5	7.9		8.0	8.0	10.0	10.0		N/A	N/A	7.4	7.4	7.5	7.5
Annual Rate of Utilization Inflation (%)	3.0	3.0	1.0	1.0		6.0	6.0	4.9	3.9		N/A	N/A	1.3	1.3	3.5	3.5
Composite Inflation Rate %	9.0	9.0	9.6	9.0	7.5	14.4	12.0	15.5	14.3	10.0	N/A	N/A	8.8	8.8	11.2	11.2
Category: Hospital Outpatient																
Annual Rate of Price Inflation (%)	5.8	5.8	7.9	7.4		5.4	5.4	7.8	7.8		N/A	N/A	7.5	7.5	7.1	7.1
Annual Rate of Utilization Inflation (%)	1.9	1.9	5.3	5.2		7.1	7.1	4.7	3.7		N/A	N/A	4.2	4.2	3.8	3.8
Composite Inflation Rate %	7.9	7.9	13.6	13.0	9.9	13.1	12.6	12.9	11.8	10.7	N/A	N/A	12.0	12.0	11.1	11.1
Category: Pharmacy																
Annual Rate of Price Inflation (%)	--	--	--			--	--	4.8	4.8		N/A	N/A	7.3	7.3	5.7	5.7
Annual Rate of Utilization Inflation (%)	--	--	--	--		--	--	5.8	4.9		N/A	N/A	2.6	2.6	3.1	3.1
Composite Inflation Rate %	11.6	11.6	11.5	11.0	11.0	12.5	12.5	11.0	9.9	9.9	N/A	N/A	10.1	10.1	9.0	9.0
Category: Primary Care																
Annual Rate of Price Inflation (%)	N/A	N/A	19.3	15.0		N/A	N/A	3.8	3.8		N/A	N/A	6.7	6.7	6.2	6.2
Annual Rate of Utilization Inflation (%)	N/A	N/A	3.5	3.7		N/A	N/A	5.9	5.0		N/A	N/A	1.3	1.3	4.0	4.0
Composite Inflation Rate %	N/A	N/A	23.5	19.3	19.3	N/A	N/A	10.1	9.0	19.3	N/A	N/A	8.1	8.1	10.5	10.5

Category: All Other Medical Care																
Annual Rate of Price Inflation (%)	4.0	4.0	3.0	2.3		1.8	1.8	3.8	3.8		N/A	N/A	5.8	5.8	3.9	3.9
Annual Rate of Utilization Inflation (%)	5.0	5.0	3.5	3.7		6.3	6.3	5.9	5.0		N/A	N/A	2.7	2.7	4.2	4.2
Composite Inflation Rate (%)	9.2	9.2	6.6	6.1	6.1	8.5	7.9	10.1	9.0	7.6	N/A	N/A	8.7	8.7	8.3	8.3
Projected Portion of Premium for Administrative Costs	14.3	14.3	17.6	14.2	14.0	18.4	17.4	17.4	16.9	16.9	N/A	N/A	13.0	12.0	13.0	13.0
Projected Portion of Premium for Reserves and Profit	2.3	1.3	2.3	2.3	2.0	1.6	1.0	1.0	1.0	1.0	N/A	N/A	-	-	-	-
Overall avg. premium increase (OHIC estimated)	9.7	8.3	13.9	11.4	9.8	12.6	9.5	13.2	10.6	6.3	N/A	N/A	9.7	8.5	9.5	9.5

Notes:

1. Annual rate of utilization inflation also includes amounts if identified separately for mix of services, demographic change and benefit leveraging.
2. United has projected a lower rate of medical inflation for periods after July 1, 2010 rates
3. Average premium increase is the average of rate increases identified by the carriers for July 1, 2010 renewals and October 1, 2010 renewals
4. Blue Cross analyzes trend on a combined basis for small and large group; United's is separate.

Overview

The Office of the Health Insurance Commissioner (OHIC) of the State of Rhode Island has a comprehensive and innovative rate review process established for all lines of commercial insurance. OHIC proposes to use federal funds available to states through the US Department of Health Human Services' (HHS) Premium Review Grant program to accomplish three goals: (1) expand the scope of current rate review and approval activities; (2) enhance the rate review process through staffing; and (3) improve consumer protection standards and communications in the rate review process. These goals align with HHS' objectives for Cycle I funding:

> (1) *Thorough evaluation of proposed health insurance rate increases and, to the extent permitted by law, (dis)approval through a comprehensive rate review process that is meaningful and transparent to all stakeholders; and*
> (2) *Infrastructure development to collect, analyze, and report to the Secretary critical information about rate filings and the review and, to the extent permitted by law, the approval and disapproval process.*

OHIC will meet HHS grant objectives, improve the effectiveness of health insurance rate regulation in Rhode Island, and provide valuable lessons for other states engaged in this process.

A. Current Health Insurance Rate Review Capacity and Process

Health Insurance Markets and Regulatory Structure in Rhode Island

In the commercial health insurance market for those under 65 years of age, there are three major medical insurers in Rhode Island: Blue Cross Blue Shield of Rhode Island (BCBSRI), United Healthcare of New England, and Tufts Health Plan. Within the state, these three insurers comprise 81%, 15%, and 4% of fully-insured market share respectively. All three sell products in the small and large group markets. Approximately 88,000 lives are covered in the small group market and 248,000 lives in the large group market. BCBSRI is the only carrier that sells individual market products in the state, covering approximately 15,000 lives. An additional 223,000 lives are covered in the commercial market through self-funded groups; however, these

groups are exempt from state-based regulation and consequently premium review. OHIC regulates all commercial health insurance products sold within the individual, small, and large group markets. In addition, approximately 32,000 residents buy Medicare supplemental ("Medigap") insurance regulated by OHIC. Certain other accident and sickness (limited benefit, limited duration, disease specific coverage) policies sold in Rhode Island are regulated under a separate set of statutes by OHIC's sister agency, the Department of Business Regulation (DBR).

Prior to 2004, DBR was authorized by statute to review proposed health insurance premium rate factors annually for small and large employers.[1] DBR, in standard practice, reviewed the variables, called "rate factors", that health insurers proposed to use in their separately approved rate manuals for calculating their premiums quotes, rather than just reviewing the aggregated dollar value of proposed rates. Using rate factors as the basis for premium review has allowed Rhode Island to closely track cost driver trends that comprise premium rates. The three primary rate factors proposed by insurers were (1) projected administrative costs, (2) contribution to reserves (also considered surplus or profit), and (3) projected medical inflation. DBR assessed each factor's trend rate for consistency with the public interest and proper conduct of business.[2] DBR reviewed the sufficiency of proposed rates to monitor the continued solvency of each insurer as well as the adequacy of benefits consumers would receive in return for their premium payments.

In 2004, the Rhode Island legislature elevated health insurance regulation within DBR with legislation that established OHIC.[3] OHIC's creation was driven by two factors: (1) a perceived need for more comprehensive statutory authority to hold health insurers accountable for financial management, and (2) a recognition that health insurance is viewed by the public as

[1] Rhode Island General Law 42-62-13, 27-19-6 and 27-20-6 (Attachments A, B, and C)
[2] Rhode Island General Law 42-62-13, 27-19-6 and 27-20-6 (Attachments A, B, and C)
[3] Rhode Island General Law 42-14.5-1 (Attachment D)

qualitatively different than other types of insurance, consequently requiring a different type of oversight and regulation. When OHIC was established, regulatory standards governing health insurer conduct were substantially broadened in statute. In addition to actuarial soundness, financial solvency, and consumer protection, two additional criteria for the public interest were added for consideration. These were: (1) fair treatment of providers and (2) improving the affordability, quality and accessibility of medical care. We are not aware of any other state that currently directs regulators to consider broad health policy factors, such as fair treatment of providers and improvements in affordability, quality, and accessibility of medical care, when reviewing health plan conduct.[4] The statute gave little guidance to OHIC for assessing what constitutes actions for fair treatment of providers and improving affordability, quality, and accessibility of care; therefore, one of OHIC's most significant regulations, its "purposes regulation", further delineated the application of these new criteria in the rate factor review process.[5] In a key strategic decision in 2006, OHIC elected to apply these criteria in the annual rate factor review for small and large group business, substantially revising the process to require insurers to file rates annually, consistently across lines of business and across insurers, and transparently. The interests of the public in affordable health insurance and the interests of the insurer in sustainable rates are most clearly identified and in conflict in the rate factor review. These conflicting interests make rate review an ideal regulatory tool for leveraging affordability.

OHIC has made considerable strides in the past few years to define and apply standards of affordability to the rate factor review. In 2008 insurers were required to submit a plan for improving health insurance affordability. This disclosure alone produced limited results, as it did not engage providers, payers, or the public to improve system-wide affordability. Therefore, in

[4] Rhode Island General Laws 42-62-13, 27-19-6, 27-20-6 (Attachments A, B, and C)
[5] OHIC Regulation 2: Purposes Regulation. Pg. 2. (Attachment E)

2009 four key standards of affordability were developed by OHIC in collaboration with the Health Insurance Advisory Council (HIAC)[6] that could be measurably applied to insurers within the rate factor review. These standards require insurers to: (1) increase each insurer's proportion of medical expenses on primary care by one percentage point per year from 2010 – 2014; (2) support expanding the medical home initiative in Rhode Island, (3) fund the adoption and maintenance of electronic medical records as a percentage of market share, and (4) participate in an on-going dialogue about comprehensive state-wide payment reform.[7] The Commissioner considers compliance with these standards when issuing rulings for the annual rate factor review.

OHIC Rate Review Process - Components

OHIC's rate review process varies by product type. In the individual market there is a single carrier with five products. An annual rate hearing process is required by statute.[8] In the Medigap market, OHIC reviews rates by product as a carrier chooses to revise them. OHIC may approve the rates, suggest modifications for resubmission or initiate an administrative hearing. The processes for small and large group rate factor review will be described in greater detail because it effects more than half of Rhode Islanders and the process is unique to the state. OHIC can approve, reject or modify the inflation factors that insurers use to calculate the rates paid by consumers. Once these rate components are determined, insurers use rating formulas to calculate an employer-specific year long, fixed rate based on that employer's benefit plan and demographic mix. Past claims experience is also considered in the large group market. For small group, rates are based on adjusted community rating, with allowed variation for age, gender, and

[6] The HIAC is a statutorily mandated advisory group to OHIC, comprised of businesses, providers and consumers.
[7] OHIC Issue Brief, May 19, 2009. Available at:
http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%20/6_Issue%20Brief.pdf
[8] Rhode Island General Laws 27-19-6 and 27-20-6 (Attachments B, and C)

family composition within a 4:1 rating band.[9] There are no equivalent statutory or regulatory requirements for large group rating rules; however, OHIC separately reviews insurers' rating formulas to ensure they are fair and are consistently applied.

The rate factor review process for small and large group rates occurs in four steps over the course of 45-60 days. These steps include: (1) preliminary internal review, (2) public comment, (3) internal actuarial and substantive review, and (4) rate factors proposal to carriers. Rate factor review for the individual market does not go through this process; rather, all individual filings automatically go to hearing pursuant to statute, as described in "Step 4" below.

Preliminary Internal Review: Health insurance carriers file their proposed rate factors utilizing the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filing (SERFF). The carriers use a standard form (Attachment H) to report their projected annual rate of price and utilization increases for the following categories: hospital inpatient, hospital outpatient, pharmacy, primary care, and all other medical, as well as the projected portion of premium for administrative costs and reserves or profits. These trends are also reported as the resulting overall average increase in commercial health insurance premiums. The Executive Counsel and consulting actuary review the proposed trend factors for completeness. They may ask for any clarifications from the health plans at this stage.

Public Comment: OHIC posts all proposed rate factors for oral and written public comment.[10] Public comments are usually collected for four weeks.[11] The rate factors are also presented to HIAC for analysis and comment. A publicly accessible rate review process assists OHIC in holding insurers accountable for goals that may conflict, including financial solvency,

[9] Rhode Island General Law 27-50-5 and OHIC Regulation 11, shown in Attachments F and G.
[10] Rhode Island General Laws that govern public disclosure and access to rate filing information include per the Access to Public Record Act (RIGL 38-1-1- et seq.), 27-19-6, 27-20-6, 42-62-13, as shown in Attachments A, B, C, and I. AG opinion PR 09-01 (http://www.riag.state.ri.us/civilcriminal/show.php?id=568) also applies.
[11] A copy of the public comment solicitation can be found as Attachment J.

consumer protections, fair treatment of providers, and implementing policies that improve affordability, quality, and accessibility of the health care system. At OHIC's discretion, rate factors may also be publicly discussed through public meetings and/or formal hearings.

Internal Review: The Health Insurance Commissioner, Executive Counsel, and consulting actuary work together to assess the actuarial soundness of proposed rate factors and their relationship to each carrier's solvency. The Superintendent of Insurance and the Chief Financial Examiner at DBR participate in this internal review as needed. In addition to financial solvency, OHIC considers the general conduct of insurers when reviewing proposed rate factors. Components considered as part of general conduct are summarized in Figure 1. OHIC also considers insurers efforts to improve system affordability, using the metrics for affordability standards as summarized in Figure 2. All internal analysis is completed using Microsoft Excel.

Propose Approved, Modified, or Rejected Rate Factors to Carriers: Upon completion of the internal review, the Health Insurance Commissioner accepts, modifies, or rejects the rate factors requested by the health insurers. OHIC sends a decision letter to each plan and allows health insurers to respond. Insurers can either re-file their rates in accordance with the proposed modifications or OHIC will call a hearing on the original filing. All rates are filed prospectively. OHIC has the authority but lacks resources to perform a comprehensive retrospective analysis to reconcile prior year's proposed versus approved rates. Market conduct examinations are generally conducted only if there is evidence or suspicion that insurers are not appropriately applying their approved rate factors to calculate premiums.

If an insurer does not re-file their rates in accordance with OHIC's proposed modifications, a full hearing is conducted in compliance with the state Administrative Procedure Act. The insurer(s) and attorney general (the attorney general is statutorily charged with representing the

public at a rate hearing) testify before a hearing officer regarding the proposed filing. The hearing officer makes a recommendation to OHIC, and the Commissioner issues a final decision. When rate factors are filed for the individual market by BCBSRI, the rate review occurs directly through a hearing, without first going through initial review, a public comment period, and internal review. Due to the statutorily mandated process required for rate hearings, individual market rate hearings usually require two months to complete. All significant final rate review decisions are posted in plain language on the OHIC web site and communicated in press releases.

Figure 1. Considerations for Evaluating Insurers' General Conduct [12]

1. Efforts by health insurers to develop benefit design and payment policies that:
- a. Enhance the affordability of products
- b. Encourage more efficient use of existing resources.
- c. Promote appropriate and cost effective acquisition of health care technology and expansion of existing infrastructure.
- d. Advance development and use of high quality health care centers.
- e. Prioritize use of limited resources.

2. 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.

3. Efforts by health insurers to promote collaboration among the state's health insurers to promote standardization of administrative practices and policy priorities.

4. 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 these system-wide improvements.

5. Participating in the development and implementation of public policy issues related to health.

6. The interests of the state's health insurance consumers, including:
- a. efforts by the health insurer to ensure that consumers are able to read and understand the terms and scope of the health insurance coverage documents issued or provided by the health insurer and make fully informed choices about the health insurance coverage provided by the health insurer;
- b. the effectiveness of the health insurer's consumer appeal and complaint procedures;
- c. the efforts by the health insurer to ensure that consumers have ready access to claims information;
- d. efforts by the health insurer to increase the effectiveness of its communications with its insureds, including, but not limited to, communications related to the insureds' financial responsibilities;
- e. ensuring that the benefits in health insurance coverage documents issued or provided by a health insurer are consistent with state laws; ensuring 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
- f. that the insurer takes steps to enhance the affordability of its products.

7. The interests of the state's health care providers, including:
- a. that the policies, procedures and practices employed by health insurers with respect to provider reimbursement, claims processing, dispute resolution, and contracting processes are understandable and transparent; and
- b. that the efforts undertaken to enhance communications with providers

[12] Source: OHIC Regulation Two (Attachment E)

Figure 2. Metrics for Evaluation of the Affordability Standards[13]

Standard 1: Primary Care Spending
- Primary care satisfaction (OHIC annual survey)
- Primary care supply: number of total primary care providers
- Primary care supply: primary care physicians as a percentage of Rhode Island physicians
- Incidence of hospitalizations for ambulatory care–sensitive conditions
- Incidence of emergency room visits for ambulatory care–sensitive conditions
- Overall Rhode Island medical trend, for fully insured, commercial business

Standard 2: Spread Adoption of the Chronic Care Model Medical Home
- Improved performance on quality measures for three chronic conditions—coronary artery disease, diabetes mellitus, and depression—
- Reduced emergency room visits, inpatient readmissions, and system costs.

Standard 3: Standard Incentives to Use Electronic Medical Records
- Rate of EMR adoption

Standard 4: Work Toward Comprehensive Payment Reform
- Development of metrics for this standard are in process

Consumer Protections and Transparency

OHIC has made rate review transparency a critical aspect of its oversight strategy. All significant rate filings are publicly disclosed and prominently posted on OHIC's website. The statutes governing the rate review process require that "any documents presented in support of a filing of proposed rates under this section shall be made available for public examination at any time and place that the director may deem reasonable".[14] In 2007, insurers were required for the first time to submit rate factors simultaneously for large and small group products for public review and consideration. OHIC posted sections of the filing and associated analysis on its website for public review and comment. In 2008, OHIC published rate factors for administrative costs, profits and surplus, and five medical service categories, as well as the price and inflation factors for each of the medical service categories. This unprecedented transparency promoted

[13] Source: OHIC Affordability Standards, Available at: http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%20/6_Issue%20Brief.pdf

[14] Rhode Island General Laws that govern public disclosure and access to rate filing information include per the Access to Public Record Act (RIGL 38-1-1- et seq.), 27-19-6, 27-20-6, 42-62-13, as shown in Attachments A, B, C, and J. AG opinion PR 09-01 (http://www.riag.state.ri.us/civilcriminal/show.php?id=568) also applies.

consumer awareness of insurance cost drivers.[15] At the conclusion of each review, the rate decision and any health plan responses are posted to OHIC's website with related press releases.

Once rate factor decisions are made public, purchasers and brokers may use this information in evaluating their own rate increases. An OHIC bulletin described a standard quote sheet for insurers to use for small businesses so consumers understand what causes premium changes.[16] Finally, OHIC investigates individual complaints from brokers and businesses regarding specific quotes as those concerns are presented to OHIC. No data are compiled on the frequency of these complaints, since efforts have been focused on the rate review process.

Current Level of Resources and Capacity for Reviewing Health Insurance Rates

OHIC is annually appropriated approximately $550,000 in the state's budget in General Revenue Funds. Additionally, OHIC receives 75% of a full-time equivalent (FTE) for work related to consumer protections such as processing complaints and reviewing policies and other filed forms and one or more FTEs for financial examination from the DBR. OHIC uses consulting staff as needed for rate review and special examinations as called by the Commissioner. OHIC received 249 rate filings in 2009, most of which were for Medicare Supplement plans or other non-major medical plans. OHIC reviews small and large group rate factors annually for each of the three major medical insurers in the state, as well as individual market rates for BCBSRI. Overall, approximately 25% of OHIC's budget is spent for rate review, most of which is dedicated to staff time and consulting fees. Actuarial expenses are billed directly to health insurers by statute.[17] The Health Insurance Commissioner, a cabinet level official, has executive authority over the rate factor review. Christopher Koller is currently

[15] See attachment K for the rate factor template for consumers.
[16] See full text of bulletin at http://www.ohic.ri.gov/documents/Insurers/AdoptedBulletins/11_2008-3%20Small%20Group%20Annual%20filing.pdf
[17] Actuarial fees are billed to insurers per Rhode Island General Law 42-14-10 (Attachment M).

Commissioner.[18] The Executive Counsel to OHIC, an attorney with both industry and regulatory experience, provides legal expertise to the rate factor review process. OHIC contracts with an independent, self-employed, out-of-state actuary for all technical analyses. Since OHIC's inception, they have used DeWeese Consulting, Inc for virtually all actuarial services. Billings for actuarial services totaled $126,000 in 2009.

Successes and Challenges

Rhode Island has established a comprehensive, transparent rate factor review process that has achieved savings for Rhode Islanders. For example, rate factor decisions made by OHIC in 2008 resulted in $15-20 million in annual savings to large employers.[19] In 2009, insurers voluntarily withdrew their requests for rate increases in the small and large group markets, which effectively froze premium rates for six months. In the individual market, OHIC granted no rate increase in 2009 and rate increases of 8.7% and 7% in 2008 and 2010. A chart summarizing proposed and approved rate factors for 2008 – 2010 can be found in Attachment L.

B. Proposed Rate Review Enhancements for Health Insurance

The process previously described situates the state as a national leader in premium review. While OHIC has made much progress in the thoroughness and public accessibility of rate reviews, these reviews could be more comprehensive and effective. Public engagement, formal standards for evaluating medical and administrative costs, and resources available for analytical review have all been limited. OHIC proposes to use funds from this grant to improve its comprehensive rate review by focusing on improved analytics and consumer engagement, as well as enhanced oversight of health insurer efforts to reduce underlying cost drivers. OHIC will

[18] See Attachment #5 for Koller's resume.
[19] OHIC Press Release, June 13, 2008. Available at: http://www.ohic.ri.gov/documents/Press/PressReleases/2008BCLargeGroupApproval/1_2008%20large%20group%20rate%20modification%20press%20release.pdf

share its monitoring and results with Federal Officials as well as make the information easily publicly accessible. To meet the objectives laid out in the grant advisory, OHIC proposes to use these grant funds to enhance health insurance rate review in the state by: (1) expanding the scope of current review and approval activities, (2) enhancing staffing, and (3) improving consumer protection standards and communications.

Expanding the scope of current rate review and approval activities

OHIC plans to allocate more than 50% of available federal funds to expand the scope of Rhode Island's current rate review and approval activities. This expansion will be primarily in two areas: (1) monitoring efforts to improve health insurance premium affordability, and (2) conducting analyses that support and inform rate review decisions.

Ensuring the affordability and sustainability of health insurance premiums has been a priority for OHIC and an integral part of the rate review process, however, the resources necessary to make the process effective have not been available. Since OHIC implemented affordability standards in 2009, initial affordability analyses have been limited and privately funded. Ongoing efforts are not built into OHIC's budget. With federal funding, OHIC will enhance its current capacity to monitor and enforce the affordability standards by hiring an external affordability consultant. Monitoring insurers' compliance with the affordability standards will be the consultant's chief responsibility. This consultant will oversee the two affordability evaluations described below, as well as engage in ad hoc analyses of underlying cost drivers of the health care delivery system. Rate factor review and enforcement will be enhanced by this improved monitoring effort, providing more information on which the Commissioner can base his/her rate rulings.

OHIC will use federal funds to support two initial affordability evaluations. OHIC will

dedicate $100,000 to complete an evaluation of the effects of its affordability standards with assistance from the RI Department of Health (HEALTH). This evaluation will assess trends in avoidable emergency room utilization, preventable hospitalizations, and readmissions. OHIC and HEALTH will establish a baseline utilization trend using historical data and produce a quarterly report to ensure close monitoring of any utilization trends or changes in trend. HEALTH will use its existing inpatient utilization database and will draw on national standards for these measures. This evaluation will also set a baseline for future inter-agency evaluations of cost drivers. The second evaluation will compare hospital payments for inpatient and outpatient care to hospital costs. Payments and costs will be evaluated by payer type (commercial, Medicare, and Medicaid) to document any cross-subsidization among payers that may contribute to rising commercial health insurance costs. This work springs directly from the initial transparency efforts by OHIC, which documented budgeted inpatient price trends of nine percent or more across all payers. Preliminary analytical work by OHIC also has documented variations in commercial insurer hospital payments by hospital but was incomplete – omitting other payers and outpatient services. These findings are not unique to Rhode Island, but understanding the phenomenon requires deeper analysis. In OHIC's experience, rate review must be connected to comprehensive delivery system analysis and transformation efforts, such as these analyses, to ensure affordable health insurance. A subcontractor will conduct the evaluation of hospital payments and costs. The affordability consultant will oversee both the utilization and hospital payment evaluations.

In addition to enhanced affordability monitoring, OHIC will expand the scope of current rate review activities with more detailed data analyses that support and inform rate factor review decisions. OHIC will contract with an actuary to reconcile past insurer rate factor requests and decisions with actual financial performance and results. OHIC has identified this need as a result

of past rate reviews, but a detailed and significant historical analysis has been outside the scope of the limited funding available for individual rate reviews. OHIC will be able to understand the financial impact of past rate decisions and health plan budgeting with the results of this analysis, facilitating a more accurate review of future rate factor filings. The analytical template will likely be useful to other states, and OHIC looks forward to sharing its results.

Finally, OHIC will subcontract with an analyst to develop a plan to align Rhode Island's current rate factor review with anticipated federal guidance for implementing premium review and for any health insurance exchange operating in Rhode Island as required by the Affordable Care Act. This dedicated analyst will also conduct an all-purpose evaluation of cost drivers throughout the grant-funded period. Analyses will include enrollment trends, financial health, interstate comparisons, benchmarks, and systemic cost drivers. The ongoing cost driver evaluation paid for by these grant funds will generate information to enhance OHIC's current rate review standards to permit the Commissioner to make more informed rate factor rulings.

Enhancing the Rate Review Process through Staffing

OHIC will use a portion of the federal grant funding to enhance staffing dedicated to the rate factor review process. Currently, OHIC has three FTE employees: the Health Insurance Commissioner, Executive Counsel, and Office Coordinator who supports both the Commissioner and the Counsel. OHIC will hire a full time rate review manager for the duration of the grant period to manage the formal rate filing process. This rate review manager will be responsible for obtaining all filings and posting decisions through SERFF. The manager will assist the actuary and Executive Counsel to review nearly 300 filings received by OHIC each year. This manager will also coordinate all communication with insurers and stakeholders related to rate review.

OHIC currently contracts with one actuary for all technical work related to the rate review

process. To enhance rate review capacity, OHIC will contract with their current external actuary to develop a robust database of past rate factor review submissions. The database will be constructed such that the manager, without actuarial expertise, may easily add future rate factor filings to the database. The manager will oversee this database development project, the ongoing maintenance of rate filing data in the database and will develop mechanisms to post this information on OHIC's website, improving the frequency with which it is used by the public.

OHIC is committed to working with HHS to develop, maintain and improve the quality of rate trend information in Rhode Island to be submitted to HHS and this person will be responsible for that function. OHIC has successfully implemented the SERFF process developed by NAIC for rate and form filing, and will invest funds as well as the manager's time with NAIC to expand and enhance SERFF to comply with Federal requirements for all data reporting.

Improve consumer protection standards and communications in the rate review process

OHIC has been committed to transparency and public disclosure of the maximum amount of information available for rate review, as well as worked to educate the public on health insurance cost drivers and the strengths and limitations of health insurance rate review. In spite of these efforts, OHIC has experienced limited public engagement with rate factor filing information – with sparsely attended public meetings and limited public comment. OHIC has few community partners in this work. Numerous special interest consumer advocacy groups exist for many government services, yet few naturally forming advocacy groups for affordable health insurance rate factors. Therefore, OHIC will dedicate a portion of these funds to contract with a community organization that can promote purchaser and consumer engagement in the rate review process. The organization would be responsible for collecting public comment and generating additional analyses relative to consumer engagement. The organization would also be

charged with raising awareness and knowledge of both the rate factor review process and underlying cost drivers of health insurance premium increases with purchasers and the public. With effective community partners, OHIC can meet several measurable goals – greater attendance at public meetings regarding rate factors, more and more informed communications regarding rate factors from the public and a more robust process for the work of the HIAC.

OHIC will contract with a consultant to communicate the results of evaluations conducted through this grant to health plans, hospitals, providers, regulators, and other interested stakeholders. OHIC will also hire a web consultant to increase traffic to OHIC's website. The designer will be responsible for recommending and implementing mechanisms for ensuring that rate filing data is readily accessible to consumers.

C. Reporting to the Secretary on Rate Increase Patterns

The OHIC attests that it will comply with the reporting requirements outlined in statute and in the grant solicitation. The rate review manager hired to manage the rate factor review process will collect and provide data to the Secretary on the timeline requested by HHS. OHIC will transmit the data using the uniform reporting template to be provided by HHS to grant awardees. OHIC will also provide trend data as requested from 2008 through 2011.

Summary: The combined enhancements to the scope of rate review and approval activities, staffing capacity, and consumer protection standards and communication in Rhode Island will greatly improve OHIC's already robust and transparent rate factor review process while aligning with any new federal premium review requirements. This proposal builds on OHIC's nation-leading work in premium rate review, meets HHS funding objectives for the Premium Review Grant, improves the effectiveness of the rate review process for Rhode Island's citizens and will provide valuable lessons for other states engaged in this important work.

GRANTS.GOV™

Grant Application Package

Opportunity Title:	"Grants to States for Health Insurance Premium Review-C
Offering Agency:	Ofc of Consumer Information & Insurance Oversight
CFDA Number:	93.511
CFDA Description:	Affordable Care Act (ACA) Grants to States for Health I
Opportunity Number:	RFA-FD-10-999
Competition ID:	ADOBE-FORMS-B
Opportunity Open Date:	06/07/2010
Opportunity Close Date:	07/07/2010
Agency Contact:	Gladys Melendez-Bohler Grant Specialist E-mail: Gladys.Melendez-Bohler@fda.hhs.gov Phone: 301-827-7168

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

☐ **This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.**

*** Application Filing Name:** RI Health Insurance Premium Review

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

Optional Documents

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

1 Enter a name for the application in the Application Filing Name field.

- This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
- You can save your application at any time by clicking the "Save" button at the top of your screen.
- The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.

2 Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.

- It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.

- The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".

- To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.

- All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.

3 Click the "Save & Submit" button to submit your application to Grants.gov.

- Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
- Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
- The "Save & Submit" button will become active; click on the "Save & Submit" button to begin the application submission process.
- You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

ERROR!

This application package has been opened and saved with a version of Adobe Acrobat or Adobe Reader that is not compatible with Grants.gov.

THIS PACKAGE IS NO LONGER VALID AND CANNOT BE SUBMITTED.

To download the Grants.gov required version visit:
http://www.grants.gov/help/download_software.jsp#adobe811

For more information: http://grants.gov/help/general_faqs.jsp#adobe

Also the Contact Center is available for further assistance. The Contact Center hours of operation are Monday-Friday, 7 a.m. to 9 p.m., Eastern Time; closed on Federal Holidays.

Email: support@grants.gov

Phone: 1-800-518-4726

ERROR!

You have attempted to open this document with a version of Adobe Acrobat or Adobe Reader that is not compatible with Grants.gov.

YOU CANNOT PROCEED WITH THIS DOCUMENT!

You are using the incorrect version: 9.304

Install the required version and try again.

To download the Grants.gov required version visit:
http://www.grants.gov/help/download_software.jsp#adobe811

For more information: http://grants.gov/help/general_faqs.jsp#adobe

Also the Contact Center is available for further assistance. The Contact Center hours of operation are Monday-Friday, 7 a.m. to 9 p.m., Eastern Time; closed on Federal Holidays.

Email: support@grants.gov

Phone: 1-800-518-4726

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Business Regulation, Rhode Island Department of

* b. Employer/Taxpayer Identification Number (EIN/TIN): 056000522

* c. Organizational DUNS: 9299560920000

d. Address:

* Street1: 1511 Pontiac Ave Bldg 69-1
Street2:
* City: Cranston
County/Parish:
* State: RI: Rhode Island
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 02920-4407

e. Organizational Unit:

Department Name: Business Regulation, RI

Division Name: Off of the Health Insurance

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Mr.
* First Name: Christopher
Middle Name: F.
* Last Name: Koller
Suffix:

Title: Heatlh Insurance Commissioner

Organizational Affiliation: Office of the Health Insurance Commissioner

* Telephone Number: 401-462-9638
Fax Number: 401-462-9645

* Email: ckoller@ohic.ri.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Premium Review Grant

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: RI-002 | b. Program/Project: RI-all

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 08/09/2010 | * b. End Date: 09/30/2011

18. Estimated Funding ($):

* a. Federal	1,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	
* First Name:	Lori
Middle Name:	
* Last Name:	Mello
Suffix:	
* Title:	Administrative Officer
* Telephone Number:	401-462-9639
Fax Number:	401-462-9645
* Email:	lmello@ohic.ri.gov
* Signature of Authorized Representative:	Completed by Grants.gov upon submission.
* Date Signed:	Completed by Grants.gov upon submission.

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

Business Regulation, Rhode Island Department of

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Project Officer and Financial Officer

Prefix:

* First Name: Christopher

Middle Name: F.

* Last Name: Koller

Suffix:

Title: Health Insurance Commissioner

Organizational Affiliation:

Office of the Health Insurance Commissioner

* Street1: 1511 Pontiac Ave

Street2: Building 69, Floor 1

* City: Cranston

County:

* State: RI: Rhode Island

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 02920-4407

* Telephone Number: 401-462-9638

Fax: 401-462-9645

* Email: ckoller@ohic.ri.gov

Delete Entry | Previous Person | Next Person

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Business Regulation, Rhode Island Department of

DUNS Number: 9299560920000

* Street1: 1511 Pontiac Ave

Street2: Building 69, Floor 1

* City: Cranston County:

* State: RI: Rhode Island

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 02920-4407 * Project/ Performance Site Congressional District: RI-all

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Premium Review Grant

*** Year:** | *** Funding Agency Goal:**

* Year:	* Funding Agency Goal:
1	Increases in health insurance premiums and rate filings are thoroughly evaluated and, to the extent permitted by law, approved or disapproved through a comprehensive rate review pr

*** Objective:**

Expand the scope of current rate review and approval activities in Rhode Island

*** Results or Benefits Expected:**

Increased understanding of cost drivers and affordability initiatives to inform rate review decisions, ultimately lower rates of trend increase in RI.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Work with affordability consultant to monitor health insurers' compliance with affordability standards, oversee utilization and hospital payment evaluations, and engage in ad hoc analyses of underlying cost drivers.	Health Insurance Commissioner	08/09/2010	09/30/2011	667
Hospital Utilization Evaluation: Complete interim evaluation of cost and utilization measures prior to completion of an all-payer database in 2011	Health Insurance Commissioner	08/09/2010	06/30/2011	667
Hospital Payment Evaluation: Evaluate hospital payments for inpatient and outpatient care by payer type and compare to costs to document any cross-subsidization.	Health Insurance Commissioner	08/09/2010	03/31/2011	1,000
Work with actuary to reconcile past rate review submissions by health insurers with the past actual financial performance.	Health Insurance Commissioner	08/09/2010	12/31/2010	62

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Contract with analyst to study cost drivers, financial data, enrollment trends, interstate comparisons, and benchmarks.	Health Insurance Commissioner	08/09/2010	09/30/2011	667

* Criteria for Evaluating Results or Benefits Expected:

Interim and final reports for the following evaluations: hospital payment, and reconciliation of past rate review submissions. Initial and regular ongoing reports for the following: hospital utilization. Regular and ad hoc reports from affordability consultant and analyst including documenting commercial insurance trend in RI compared to other states

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

You may attach up to 17 additional Objective Work Plan forms here. To extract, fill and attach each additional form, follow these steps:

- Select the "Select to Extract the Objective Work Plan Attachment" button below.

- Save the file using a descriptive name to help you remember the content of the supplemental form that you are creating. When assigning a name to the file, please remember to give it the extension ".pdf" (for example, "Objective_1.pdf"). If you do not name your file with the ".pdf" extension you will be unable to open it later, using Adobe Reader.

- Use the "Open Form" tool on Adobe Reader to open the new form you just saved.

- Enter your additional Objective information in this supplemental form, similar to the Objective Work Plan form that you see in the main body of your application.

- When you have completed entering information in the supplemental form, save and close it.

- Return to this page and attach the saved supplemental form you just filled in, to one of the blocks provided on this "attachments" form.

Important: Attach additional Objective Work Plan forms, using the blocks below. Please remember that the files you attach must be Objective Work Plan PDF forms that were previously extracted using the process outlined above. Attaching any other type of file may result in the inability to submit your application to Grants.gov. Note: It is important to attach completed forms only. Attach ONLY PDF (.pdf) forms where ALL required fields are filled out. Incomplete or missing data will cause your application to be rejected.

Select to extract the Objective Work Plan Attachment

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment
16) Please attach Attachment 16		Add Attachment	Delete Attachment	View Attachment
17) Please attach Attachment 17		Add Attachment	Delete Attachment	View Attachment

OMB Number: 4040-0003
Expiration Date: 09/30/2011

Project Abstract

The Project Abstract must not exceed one page and must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

* Please click the add attachment button to complete this entry.

Add Attachment | Delete Attachment | View Attachment

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:**

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:**

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Premium Review Grant	93.511	$	$	$ 1,000,000.00	$	$ 1,000,000.00
2.						
3.						
4.						
5. Totals		$	$	$ 1,000,000.00	$	$ 1,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) Premium Review Grant	(2)	(3)	(4)	Total (5)
a. Personnel	$ 80,000.00	$	$	$	$ 80,000.00
b. Fringe Benefits	29,600.00				29,600.00
c. Travel	3,800.00				3,800.00
d. Equipment	4,500.00				4,500.00
e. Supplies	5,000.00				5,000.00
f. Contractual	855,000.00				855,000.00
g. Construction	0.00				
h. Other	22,100.00				22,100.00
i. Total Direct Charges (sum of 6a-6h)	1,000,000.00				$ 1,000,000.00
j. Indirect Charges	0.00				$
k. TOTALS (sum of 6i and 6j)	$ 1,000,000.00	$	$	$	$ 1,000,000.00
7. Program Income	$ 0.00	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000.00	$ 359,208.00	$ 301,208.00	$ 186,459.00	$ 153,125.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 1,000,000.00	$ 359,208.00	$ 301,208.00	$ 186,459.00	$ 153,125.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks: For the purposes of forecasting cash needs, Q1 = 8/9/10 - 12/31/10; Q2 = 1/1/11 - 3/31/11; Q3 = 4/1/11 - 6/30/11; Q4 = 7/1/11 - 9/30/11.

OMB Approval No.: 4040-0007
Expiration Date: 07/30/2010

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	Administrative Officer
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Business Regulation, Rhode Island Department of	Completed on submission to Grants.gov

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

*Name: Office of the Health Insurance Commissioner

*Street 1: 1511 Pontiac Ave Building 69 1st floor Street 2:

*City: Cranston State: RI: Rhode Island Zip: 02920

Congressional District, if known: RI-002

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:
Department of Health and Human Services

7. * Federal Program Name/Description:
Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, *if applicable*: 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*
$

10a. Name and Address of Lobbying Registrant:

Prefix: *First Name: NA Middle Name:

*Last Name: NA Suffix:

*Street 1: NA Street 2: NA

*City: NA State: RI: Rhode Island Zip:

b. Individual Performing Services (including address if different from No. 10a)

Prefix: *First Name: NA Middle Name:

*Last Name: NA Suffix:

*Street 1: Street 2:

*City: State: Zip:

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** Prefix: *First Name: Christopher Middle Name: F.

*Last Name: Koller Suffix:

Title: Health Insurance Commissioner **Telephone No.:** 401-462-9638 **Date:** Completed on submission to Grants.gov

OMB Number: 2125-0611
Expiration Date: 03/31/2010

Basic Work Plan

1. Estimated date of established funding agreement with State:

Note: Tasks starting before this date are not eligible for funding, and cannot be counted toward matching funds.

Describe the tasks in the work plan:

2 a. Describe this task or milestone:

b. Name of person or organization responsible for carrying out task:

c. How long will this task take to complete? months

d. Justify how this project task contributes to project completion: (800 character limit - about 133 words)

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Project Abstract Summary

Program Announcement (CFDA)

93.511

*** Program Announcement (Funding Opportunity Number)**

RFA-FD-10-999

*** Closing Date**

07/07/2010

*** Applicant Name**

Business Regulation, Rhode Island Department of

*** Length of Proposed Project**

Application Control No.

Federal Share Requested (for each year)

*** Federal Share 1st Year**

$

*** Federal Share 2nd Year**

$

*** Federal Share 3rd Year**

$

*** Federal Share 4th Year**

$

*** Federal Share 5th Year**

$

Non-Federal Share Requested (for each year)

*** Non-Federal Share 1st Year**

$

*** Non-Federal Share 2nd Year**

$

*** Non-Federal Share 3rd Year**

$

*** Non-Federal Share 4th Year**

$

*** Non-Federal Share 5th Year**

$

*** Project Title**

Premium Review Grant

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Project Abstract Summary

*** Project Summary**

*** Estimated number of people to be served as a result of the award of this grant.**

Other Attachment File(s)

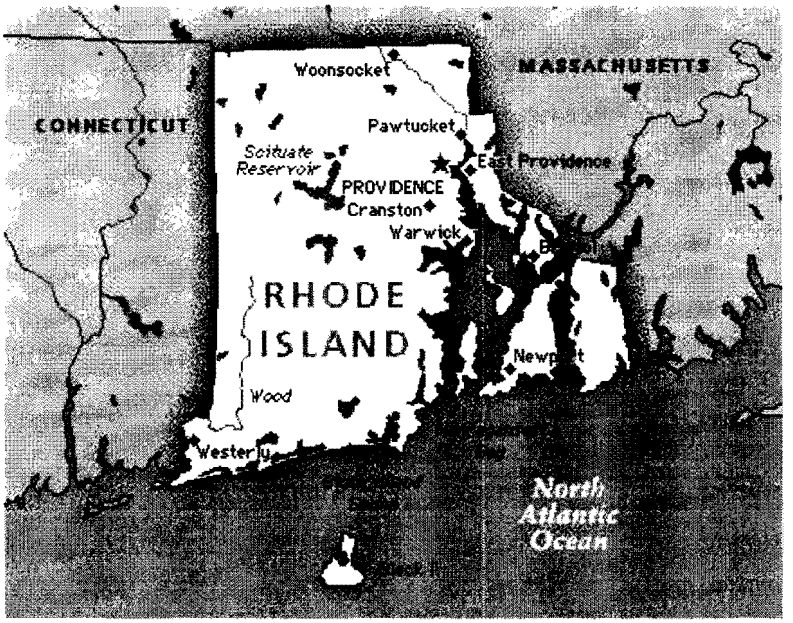
*** Mandatory Other Attachment Filename:**

Add Mandatory Other Attachment | Delete Mandatory Other Attachment | View Mandatory Other Attachment

To add more "Other Attachment" attachments, please use the attachment buttons below.

Add Optional Other Attachment | Delete Optional Other Attachment | View Optional Other Attachment

STATE OF RHODE ISLAND



Required Supporting Documentation

The Office of the Health Insurance Commissioner is well-equipped to implement the proposed grant activities. Each OHIC staff member currently spends approximately 25% of his or her time on rate reviews. Figure 1 illustrates the organizational chart for the Office of the Health Insurance Commissioner and the responsibilities for activities proposed as part of this grant application. Christopher Koller currently holds the position of Health Insurance Commissioner, a cabinet-level official appointed by the Governor. See Attachment 6 for the Commissioner's resume. The Executive Counsel provides all legal counsel to OHIC. Both industry and regulatory experience are required for this position. OHIC's consumer protection and financial solvency monitoring and enforcement activities are carried out by staff at the Department of Business Regulation, which is co-located with OHIC. OHIC receives a 0.75 full-time employee (FTE) for consumer protections and one FTE for financial examination from the DBR. Additional administrative services (budgeting and finance, IT, building services etc.) are provided by the Department of Business Regulation. OHIC uses consulting staff as needed for rate review and market conduct examinations as called by the Commissioner.

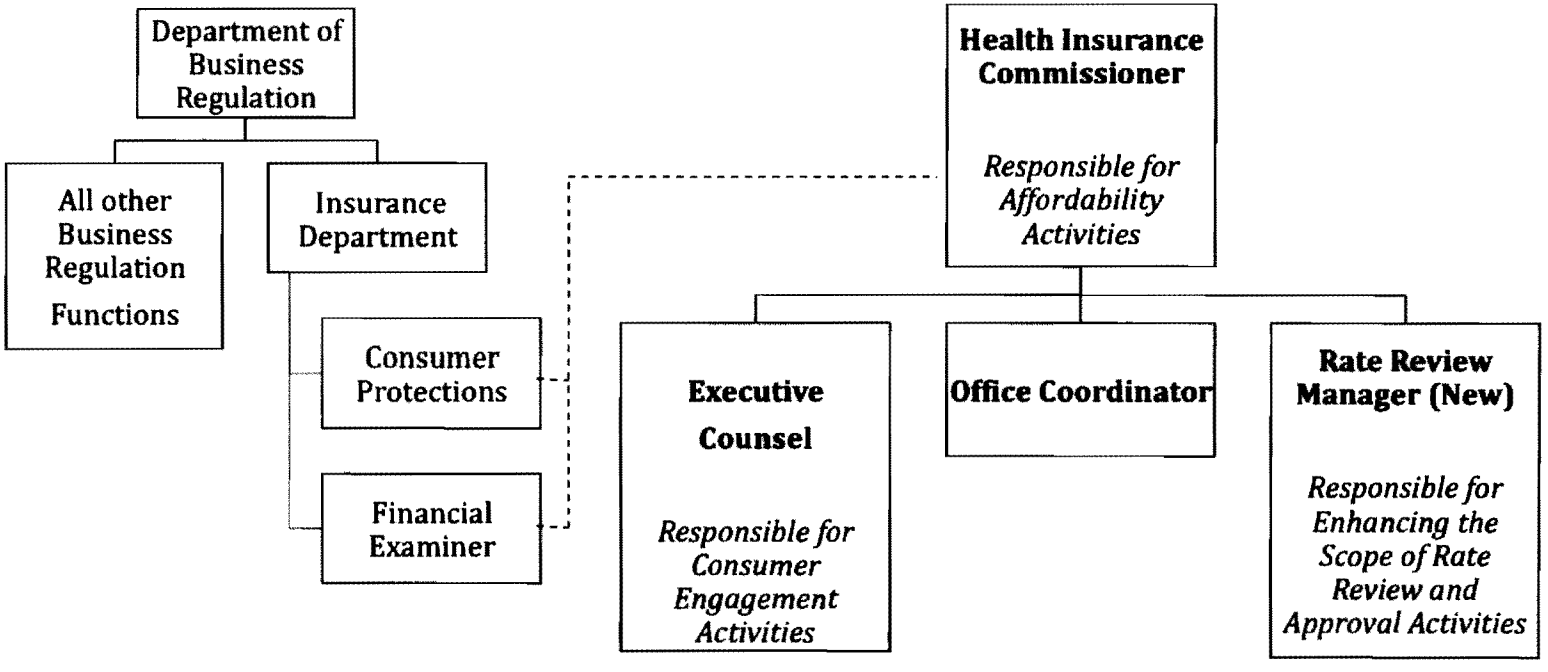
The Commissioner has final authority in rate review decisions. Currently, the Commissioner, and the Executive Counsel actively participate in the rate review process. OHIC contracts with one external, out-of-state actuary for all technical review of proposed rates. Costs for all consulting services are billed directly to the filing health insurers per statute. If a rate hearing is required (as in the individual market) or called by the Commissioner, a hearing officer is appointed and all costs associated with the hearing are borne by the filing insurer.

For the enhanced rate review activities proposed in this application, Commissioner Koller will oversee all work. The affordability initiatives activities, including the affordability

consultant, will directly report to him (see Figure 1). The Executive Counsel will oversee all consumer engagement activities funded by this grant. The Rate Review Manager position will be established under this grant. The Premium Review Grant will fully fund this position, and the Coordinator will spend 100% of his or her time on grant activities. The Rate Review Manager will be the primary program contact for the grant with the Commissioner easily accessible. The Office Coordinator and the Rate Review Manager will administer the grant for OHIC, with assistance by the Chief Financial Officer of the Department of Business Regulation. OHIC has previously administered other HHS and private grants, including High Risk Pool planning grants.

It is estimated that Commissioner Koller will spend about 25 percent of his time on the activities described in the grant and the Counsel will spend 15 percent. All current staff time will be supported by the existing state funds to ensure that grant funds will not supplant existing state expenditures for rate review activities.

OHIC Organizational Chart and Division of Responsibilities for Proposed Activities in the Rate Review Grant



(b)(6)

401/462-9638 (work); (b)(6) **(home);** (b)(6)

Professional Summary

Health Insurance Executive, Regulator and Policy Leader. Nationally recognized experience in Medicaid Managed Care, Health Policy Leadership and Health Plan Regulatory Development. Career has focused on aligning private and public systems to achieve public progress in health care efficiency, access and quality.

Employment Summary

2005-current:	Health Insurance Commissioner, State of Rhode Island
1996-2005	Chief Executive Officer, Neighborhood Health Plan of Rhode Island
1989-1996:	Management Positions, Health Care Plan Inc, Buffalo, NY
	Medical Advisor and Consultant, The HMO Group, New Brunswick, NJ
1984-1986:	Research Assistant, The Urban Institute, Washington, DC
1983-1984:	Bread for the City, Washington DC

Health Policy and Regulation

- First Health Insurance Commissioner in country. Hired staff, established regulatory structure based on broad statutory guidance and focused health plans on their new responsibilities for improving efficacy of RI's heath care system, using new and existing regulatory levers of reserve adequacy, rate oversight, market conduct and financial examinations, and consumer protection.

- Led public process to define standards for commercial insurers in improving affordability of medical care, focusing on primary car infrastructure and provider payment reform. Restructured rate factor review process to reinforce these standards; and raise awareness, transparency and accountability.

- Developed, helped pass and implemented legislation and regulation promoting small business health insurance access, insurer reserves, transparency, consumer protection, provider/health plan relationships, primary care payment reform etc.

-Health Policy Coordinator for Administration of Governor Donald Carcieri. Established five point health care agenda for Governor. Developed interagency work structure for carrying out work and documenting progress, using state's regulatory, purchasing, measurement, contracting and licensing authorities. Led or co-led ongoing interagency work in three of these areas: Health Information Technology, Delivery System Development and Insurance Access.

- Wrote, obtained and managed public and private grants to advance health policy work in state, including all payer initiative for primary care, studies of uninsured trends and policy options to reduce the number of uninsured, role of insurance exchanges and high risk pools.

- Extensive public appearances and coalition-building with stakeholders to promote Office and Agenda, and to educate community. National presenter and advisory board member for NAIC, NASHP, State Coverage Initiatives, Commonwealth Fund, Center for Health Care Strategies.

HMO Development and Leadership

-CEO for 73,000 member 180 employee HMO with $200 million in annual revenues serving mostly Medicaid Recipients in state's Community Health Centers and a broad physician network.

-Set strategic direction and business priorities for organization. Hired staff, built management infrastructure and clarified governance. Led negotiations with state and major providers. Negotiated new contracts with health centers using performance-based incentives to align priorities. Negotiated first-in-nation investment from community foundation and conversion to 501-c-3. Expanded lines of business to new Medicaid populations. Governance formation.

-Results: Organizational profitability. Membership increase of 200 %.Second Medicaid health plan in country to attain "Excellent" NCQA accreditation. Number One ranking among Medicaid Health Plans in US News and World Report. New models for health plan services with special needs

populations. Clear recognition for role of plan, its expertise with underserved populations and its delivery system in state health system among various local and national constituents.

- Founding Chair of the Association of Community Affiliated Plans – leading national association of non profit community based Medicaid Managed Care Organizations.

HMO Operations and Contracting

-Part of team which started up network model HMO to run side by side with existing staff model. Responsibilities during start up included business plan development, reimbursement modeling (based on full risk medical service accounts model), provider recruiting, information system testing and implementation, interim management of clinical services area and drafting first quality management plan Responsible for carve out capitated contracts for commercial, Medicare, Medicaid and ASO lines of business..

- (For Staff Model HMO). Responsible for specialty professional services contracting for 90 physician medical group. Responsible for clinical and non-clinical operations at 30,000 member staff model HMO medical center with twenty physicians. Direct supervision of staff of eighty in four departments over three shifts. Oversaw building expansion and telecommunications upgrades.

Medical Management Consulting

- For The HMO Group, a national consortium of 20 not for profit staff and group model HMOs, developed a Technology Management Project to advise Medical Directors on new technology issues.

- Managed Care Consultant to the Federal Bureau of Primary Health Care, its funded Community Health Centers, their Integrated Service Networks and state Primary Care Associations.

Research and Education

- Associate Professor, Program in Public Health, Brown University. Lecture in MD, MPH and undergraduate courses. Advise Health Services Researchers at University.

Education

Yale School of Organization and Management New Haven, Connecticut
Master's degree in Public and Private Management (MPPM), 1989.
Elm-Ivy Award, 1987.

Yale Divinity School New Haven, Connecticut
Master of Arts degree (MAR), Social Ethics concentration, 1989.

Dartmouth College Hanover, New Hampshire
AB, summa cum laude, Math/Econ 1983. Elected to Phi Beta Kappa, and Casque and Gauntlet. Ranny B. Cardozo Prize. Rufus Choate Scholar.

Other - Publications: "Rhode Island's Novel Experiment To Rebuild Primary Care From The Insurance Side" (with Brennan and Bailit), Health Affairs, v29n2, "Information on Malpractice: A Review of Empirical Research on Major Policy Issues", (with Zuckerman and Bovbjerg), Law and Contemporary Problems, v48 n2. "State Health Insurance Pools: Current Performance and Future Prospects", (with Bovbjerg), Inquiry, v23 n2. Articles for "Commonweal" and "HMO Practice".
- Past Chair of the Assocn of Community Affiliated Plans, RI Assocn of HMOs and Jesuit Volunteer Corps:East. Also serve on Board of Directors of Rhode Island Quality Institute, and various community agencies. Annual Campaign Chair: Fund for Community Progress. Member: Leadership Rhode Island 1998. Coach – various youth sports.
- Study and travel in Canada, Central America, Europe, and South Asia. Conversant in French and (sort of) Spanish. Enjoy choral music, baking, running and almost anything else out of doors.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

July 5, 2010

Jay Angoff
Director
Office of Consumer Information and Insurance Oversight, HHS
Room 738 G
HHH Building
200 Independence Ave, SW
Washington DC 20201

Dear Mr. Angoff,

The Office of the Health Insurance Commissioner of the State of Rhode Island enthusiastically submits this application for the Premium Review Grant to the Office of Consumer Information and Insurance Oversight within the Department of Health and Human Services.

Rhode Island has been a national leader in developing an annual rate review process that ensures health insurance carriers protect consumers, remain financially solvent, treat providers fairly, and implement policies to improve the quality, accessibility, and affordability of care. The Health Insurance Commissioner has existing statutory and regulatory authority to approve, modify or reject proposed rate increases for commercial health insurance plans in Rhode Island

We look forward to the opportunity provided by this grant to advance rate review efforts. If awarded, Rhode Island will expand the scope of our current review and approval activities, enhance staffing capacity for rate review, and enhance consumer protection standards. Christopher F. Koller, Health Insurance Commissioner, will direct all activities associated with enhancing the rate review process in the state.

Thank you for your consideration. Please contact Commissioner Koller directly at 401-462-9638 with any questions.

Sincerely,

Christopher F. Koller
Health Insurance Commissioner

www.ohic.ri.gov
1511 Pontiac Avenue • Building #69, First Floor • Cranston, RI 02920
401.462.9517 • 401.462.9645 fax • TTY: 711