**State of Rhode Island and Providence Plantations**
**OFFICE OF THE HEALTH INSURANCE COMMISSIONER**
**1511 Pontiac Ave., Building 69-1**
**Cranston, RI 02920**

**NOTICE OF PROPOSED REGULATION, NOTICE OF PUBLIC HEARING AND CONCISE SUMMARY**

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

**Office of the Health Insurance Regulation 17 – Filing and Review of Health Insurance Plan Forms and Rates**

Concise Summary. The proposed Regulation is designed to update the policies and procedures of the Office with respect to the filing and review of health insurance plan forms and rates, and to conform those policies and procedures to the requirements of the federal Affordable Care Act.

Notice of Public Hearing. Notice is also hereby given, in accordance with R.I. Gen. Laws § 42-35-3, that the Office will hold a public hearing beginning at 10:00 a.m. on Friday, December 21, 2012 in the First Floor Conference Room of the Department of Labor and Training, 1511 Pontiac Ave., Building 73, Cranston, RI 02920, regarding the Proposed Regulation.

Copies of the Proposed Regulation are on file at the Office and copies may be obtained from the Office of the Health Insurance Commissioner, 1511 Pontiac Ave., Building 69-1, Cranston, RI 02920 during normal working hours on regular business days or by mail upon request. The Proposed Regulation may also be obtained from the Office's website www.ohic.state.ri.us.

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

All interested persons may submit their views, data or arguments regarding the Proposed Regulation orally at the public hearing or in writing, either by delivering the same in person or United States mail with postage pre-paid thereon to the Office of the Health Insurance Commissioner, 1511 Pontiac Ave., Building 69-1, Cranston, RI 02920, attention Herbert W. Olson, Legal Counsel ,or by e-mail to HealthInsInquiry@ohic.ri.gov attention Herbert W. Olson, Legal Counsel.

ALL WRITTEN SUBMISSION MUST BE RECEIVED NOT LATER THAN FRIDAY, DECEMBER 21, 2012 AT 10:00 A.M.

The hearing room is accessible to the handicapped. Individuals requesting interpreter services for the hearing impaired must notify the Office at (401) 462-9517 not less than ninety-six (96) hours in advance of the hearing date.

Christopher Koller
Commissioner, Office of the Health Insurance Commissioner

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# OFFICE OF THE HEALTH INSURANCE COMMISSIONER REGULATION 17 - FILING AND REVIEW OF HEALTH INSURANCE PLAN FORMS AND RATES

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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, 27-18-8, 27-18-8.4, 27-19-6, 27-20-6, 27-41-29.2, and 42.62-12(b)(4).

## Section 2. Purpose and Scope

(a) The purpose of this Regulation is:

(1) to establish procedures for the filing of health insurance plan rates, rating formulas, rating manuals, and forms with the Office of the Health Insurance Commissioner by health insurance issuers;

(2) to establish standards for the approval or disapproval of health insurance plan forms; and

(3) to establish standards for the approval, disapproval or modification of health insurance plan rates, rating formulas, and rating manuals.

(b) In the case of any conflict between the provisions of this Regulation relating to the filing, review, approval, or disapproval of rates, rating formulas, rating manuals, and health insurance plan forms, and the provisions of any other Regulation of the Office, the provisions of this Regulation shall control and apply. The provisions of this Regulation are intended to supersede Part XI of Regulation 23, adopted by OHIC Regulation 1, entitled "Filing of Forms and Rates."

**Section 3. Definitions**

As used in this regulation:

(1) "Actuarial value" means the level of coverage provided by an issuer of a health insurance plan's benefits, as further defined in 42 U.S.C. § 18022(d) and regulations adopted there under.

(2) "Commissioner" means the Commissioner of the Office of the Health Insurance Commissioner.

(3) "Essential health benefits" means health insurance plan coverage of the benefits required by 42 U.S.C. § 18022(b), including if applicable any benchmark plan designated by the Commissioner on behalf of the Governor;

(4) "Exchange" means the Rhode Island Health Benefits Exchange established by Executive Order No. 11-09, issued on September 19, 2011.

(5) "Health insurance issuer" 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.

(6)(A) "Health insurance plan" means a policy, contract, certificate or other evidence of agreement to provide "health insurance coverage," as defined in R.I. Gen. Laws §§ 27-18.5-2(7) and 27-18.6-2(15), or to provide a "health benefit plan," as defined in R.I. Gen. Laws § 27-50-3(2), including a plan of Medicare Supplemental insurance, and a plan of dental insurance. The term shall include a qualified health plan offered on the Exchange, and a qualified health plan offered on the Exchange by the Small Business Health Options Program.

(B) The term shall include a health insurance plan in which the certificate or other evidence of coverage is offered, issued, delivered or renewed to an individual resident in this state, or to the employees or members and their dependents of a small group or employer located in this state where the health insurance plan is issued or delivered outside this state, and the plan offers or provides such coverage through a trust, association or other intermediary.

(7) "Office of the Health Insurance Commissioner" or "Office" means the agency established pursuant to R.I. Gen. Laws §§ 42-14.5-1 et seq.

(8) "Qualified health plan" means a health insurance plan that has been approved by the Office, certified by the Exchange, and with respect to which the Issuer has been licensed by the Office and certified by the Exchange, in accordance with 42 U.S.C. Chapter 157, Subchapter III and regulations adopted thereunder.

(9) "Risk adjustment and reinsurance" means the programs authorized by 42 U.S.C. § 18061 et seq.

(10) "SERFF" means the System for Electronic Rate and Form Filing administered under the auspices of the National Association of Insurance Commissioners.

(11) "Small Business Health Options Program, or SHOP, means the program authorized by 42 U.S.C. § 18031(b)(1)(B).

**Section 4.** Filing of Health Insurance Plan Forms

(a)(1) No health insurance plan shall be offered, issued, delivered or renewed to any person or entity in this state, nor shall a certificate or other evidence of coverage of a health insurance plan defined in Section 3(6)(B) be offered, issued, delivered or renewed unless all forms used in connection with the health insurance plan, including but not limited to any application, rider, endorsement, certificate of coverage, policy, subscriber contract, or group master contract, have been filed in a complete manner with the Office, and the filing is approved by the Commissioner.

(2) Individual and small group market Plans (including qualified health plans sold on the Exchange) proposed to be effective between January 1, 2014 and December 31, 2014 shall be filed with the Commissioner on or before March 1, 2013, unless a waiver of such filing deadline is approved by the Commissioner.

(3) The Commissioner shall notify the Issuer when the filing is deemed complete. Nothing in this subdivision (3) is intended to limit the obligation of Issuers to provide information relating to the filing requested by the Commissioner after the filing is deemed complete.

(b)(1) The prior approval required by subsection (a) of this section shall not apply to the following forms: summaries of benefits and coverage, advertisements other than those used in connection with a Medicare supplemental health insurance plan, and marketing and marketing training materials.

(2) A health insurance issuer shall maintain for five (5) years all records of the forms and materials not required to be filed under this subsection (b). Upon notice of the Commissioner, the health insurance plan issuer shall file with the Commissioner, within the time prescribed in the notice, any form, summary of benefits and coverage, advertisement, marketing training and other marketing materials, and any other related materials used by the health insurance issuer in connection with any health insurance plan. An issuer's obligations under this subsection are in addition to the issuer's obligations under Department of Business Regulation 67, adopted as OHIC Regulation 1, and any other applicable records retention laws and regulations.

(c) The Commissioner may delegate to an employee or official of the Office, or of the Division of Insurance of the Department of Business Regulation, his or her authority to receive, approve or disapprove forms and related materials filed under this section.

(d) The Commissioner may authorize the use of filing instructions prescribing or verifying the content of health insurance plan forms, and verifying the issuer's compliance with the laws and regulations applicable to the use of such health insurance plan forms. A health insurance plan filing is not made in a complete manner unless it is

filed by means of SERFF, and unless it is filed in accordance with the Commissioner's filing instructions.

(e) The Commissioner's filing instructions with respect to health insurance plans may include: (i) the completion of a Checklist of requirements for the content of health insurance plans; and (ii) sworn verification of a Compliance Attestation demonstrating the Issuer's compliance with the laws and regulations applicable to the use of such health insurance plan forms. The Checklist and the Compliance Attestation for individual and small group health insurance plans may relate to the following matters:

(1) Coverage of essential health benefits in connection with an individual or small group health insurance plan, including a qualified health plan.

(2) Cost sharing requirements in connection with an individual or small group health insurance plan, including a qualified health plan.

(3) Coverage required by federal or state laws and regulations.

(4) Designation of actuarial values, expressed in terms of "metallic color", in connection with individual and small group health insurance plans, including qualified health plans.

(5) Consumer disclosure of benefits, coverage and cost-sharing, claims payment policies and procedures, and standards and procedures relating to utilization review, grievances, internal appeals, and external appeals, termination of enrollment, notice of termination, nonpayment of premium, notice of nonpayment of premium, and grace periods for nonpayment of premium, in accordance with federal and state laws and regulations.

(6) Accreditation of an issuer's highest volume product line across both the individual and small group markets, and of all of an issuer's product lines offered on the Exchange.

(7) Compliance of the health insurance issuer, including issuers of qualified health plans, with federal laws and regulations relating to network adequacy and provider directories.

(8) Compliance with state laws and standards relating to network adequacy, as set forth in the letter from Director Michael Fine, MD to Commissioner Koller and Director Ferguson dated December 21, 2012.

(9) Compliance with federal and state laws and regulations, (including Department of Health regulations) relating to utilization review, grievances, internal appeals, and external appeals.

(10) Compliance with federal laws and regulations relating to the summary of benefits and coverage applicable to the health insurance plan, including a qualified health plan.

(11) Compliance with federal requirements concerning non-discrimination of plan offerings in all locations of the state.

(12) Compliance with federal and state laws and regulations relating to an issuer's obligations to subscribers and insureds with respect to termination of enrollment,

notice of termination, nonpayment of premium, notice of nonpayment of premium, and grace periods for nonpayment of premium.

(13) Compliance with federal requirements relating to non-discrimination, as provided for in 45 CFR § 156.200(e).

(14) In connection with qualified health plans only:

(A) Compliance with federal requirements with respect to the offering of a minimum number of actuarial value tiered qualified health plans, and the offering of child-only qualified health plans.

(B) Compliance with federal requirements relating to individual and SHOP enrollment, enrollment notification, and enrollment periods.

(C) Compliance with qualified health plan certification requirements to be issued and revised from time to time by the Exchange in accordance with federal and state laws and regulations, including 45 C.F.R. §§ 155.1000 et seq. and 45 C.F.R. §§ 156.200 et seq., unless the Commissioner determines that the certification requirement has not been included in the Commissioner's authorized filing instructions because the requirement is contrary to federal or state laws and regulations, or is contrary to the public interest.

(14) Any other matter necessary or desirable for the Commissioner to determine whether the filing satisfies the standards for approval established by law or regulation.

(f) The Commissioner's filing instructions applicable to the content of qualified health plans shall include all relevant qualified health plan certification standards to be issued and revised from time to time by the Exchange in accordance with federal and state laws and regulations, including 45 C.F.R. §§ 155.1000 et seq. and 45 C.F.R. §§ 156.200 et seq., unless the Commissioner determines that the certification requirement is contrary to federal or state laws and regulations, or is contrary to the public interest. The Commissioner shall also solicit and consider the recommendations of the Exchange in connection with the authorization of filing instructions applicable to the content of qualified health plan forms. The Office shall notify the Exchange upon the filing of a qualified health plan form with the Office and upon request of the Exchange shall promptly transmit any such filed qualified health plan form to the Exchange. At the request of the Exchange, the Office shall consider the comments of the Exchange with respect to the approval or disapproval of the qualified health plan form. The Office shall promptly transmit to the Exchange each qualified health plan form approved by the Office, together with data filed by the issuer in connection with the qualified health plan form. The Commissioner's approval of a qualified health plan form shall constitute approval of the content of the qualified health plan form, but shall not constitute certification on behalf of the Exchange with respect to any other aspect of the plan.

(g) The issuers' Checklist and Compliance Attestation shall be incorporated by reference into the insurance plan form, for purposes of R.I. Gen. Laws §§ 27-18-8, 27-19-7.2, 27-20-6.2, and 27-41-29.2.

(h) A form filed in a complete manner shall be deemed approved unless disapproved by the Commissioner within 60 days of the filing of the form in a complete manner.

(i) A health insurance plan form shall not be approved if the Commissioner determines that it is contrary to the public interest, or contrary to the requirements of the laws and regulations applicable to the health insurance plan form, including the requirements of this Regulation. A form shall be considered contrary to the public interest if it fails to comply with the Commissioner's authorized filing instructions, or if the issuer fails to properly complete an applicable Checklist, or fails to file an applicable Compliance Attestation.

(j) In connection with the Commissioner's approval of a health insurance plan form, the Commissioner may attach such conditions as the Commissioner determines are necessary for the plan to be consistent with the public interest, and consistent with the requirements of the laws and regulations applicable to the health insurance plan form. Such conditions may establish issuer obligations relating to:

(1) issuer compliance with laws and regulations relating to marketing standards of conduct, and with requirements relating to marketing training and materials;

(2) issuer compliance with state laws and regulations (including Department of Health regulations) relating to the certification of health plans;

(3) issuer compliance with federal and state laws and regulations (including Department of Health regulations) relating to utilization review, grievances, internal appeals, and external appeals;

(4) issuer compliance with federal requirements with respect to discrimination against individuals with significant health needs; and

(5) any other necessary and proper issuer obligation.

(k) A health insurance issuer may appeal the final decision of the Commissioner in accordance with R.I. Gen. Laws § 42-35-15.

**Section 5. Filing of Health Insurance Plan Rates, Rating Formulas, and Rate Manuals - General**

(a) No health insurance plan shall be offered, issued, delivered or renewed to any person or entity in this state unless the rates, the rating formula, and the rate manual used in connection with the plan have been filed in a complete manner with the Office, and the filing is approved by the Commissioner, or approved as modified by the Commissioner. The provisions of R.I. Gen. Laws § 27-50-5(h) shall apply to the rating practices and renewal underwriting practices of health insurance issuers of small group health insurance plans.

(2) Rates, rating formulas and rate manuals for individual and small group market Plans (including qualified health plans sold on the Exchange) proposed to be effective between January 1, 2014 and December 31, 2014 shall be filed with the Commissioner on or before April 1, 2013, unless a waiver of such filing deadline is approved by the Commissioner.

(3) The Commissioner shall notify the Issuer when the filing is deemed complete. Nothing in this subdivision (3) is intended to limit the obligation of Issuers to provide information relating to the filing requested by the Commissioner after the filing is deemed complete.

(b) The Commissioner may delegate to an employee or official of the Office or of the Division of Insurance of the Department of Business Regulation his or her authority to receive, approve, disapprove, or approve as modified rates, rating formulas, and rate manuals filed under this section.

(c) A health insurance rate, rating formula, or rate manual filing is not made in a complete manner unless it is filed by means of SERFF, and unless it is filed in accordance with filing instructions authorized by the Commissioner.

(d) The Commissioner may authorize the use of filing instructions prescribing the content of a health insurance rate filing, rating formula filing, or rate manual filing. and requiring the filing of evidence of the issuer's compliance with its obligations relating to the matters identified in subdivisions (e)(1) through (9) of this section.

(e) Such filing instructions may include content requirements and evidence of compliance with issuer obligations relating to:

(1) actuarial statements and analysis;

(2) the rate schedule, rating formula, or rate manual;

(3) the benefits, coverages, limitations and exclusions to which the rates, rating formula, or rate manual shall apply;

(4) proposed premiums for health insurance plans in the individual and small group markets, including individual and SHOP qualified health plans offered on the Exchange;

(5) issuer participation in any risk adjustment program or a reinsurance program administered in connection with health insurance plans;

(6) compliance with federal and state rating and underwriting requirements, and with the prohibition on variability of rates by geographical area;

(7) the issuer's allocation of medical loss ratio rebate amounts, if applicable, together with any medical loss ratio and rebate calculations, and any other medical loss ratio and rebate information reported to the U.S. Secretary of Health and Human Services during the previous 12 months;

(8) in connection with qualified health plans only:

(A) issuer compliance with the segregated accounting of premium allocations for abortion services;

(B) issuer compliance with federal rate year requirements;

(C) uniform plan pricing requirements for plans offered inside and outside the Exchange;

(D) issuer compliance with qualified health plan certification requirements to be issued and revised from time to time by the Exchange in accordance with federal and state laws and regulations, including 45 C.F.R. §§ 155.1000 et seq. and 45 C.F.R. §§ 156.200 et seq., unless the Commissioner determines that the certification requirement has not been included in the Commissioner's authorized filing instructions because the

requirement is contrary to federal or state laws and regulations, or is contrary to the public interest; and

(9) any other necessary or desirable content requirement or evidence of compliance.

(f) The Commissioner's filing instructions applicable to the content of qualified health plan rates, rating formulas, and rate manuals shall include all relevant qualified health plan certification standards to be issued and revised from time to time by the Exchange in accordance with federal and state laws and regulations, including 45 C.F.R. §§ 155.1000 et seq. and 45 C.F.R. §§ 156.200 et seq., unless the Commissioner determines that the certification requirement is contrary to federal or state laws and regulations, or is contrary to the public interest. The Commissioner shall solicit and consider the recommendations of the Exchange in connection with the authorization of filing instructions applicable to qualified health plan rates, rating formulas, and rate manuals. The Office shall notify the Exchange upon the filing of a qualified health plan rate with the Office and upon request of the Exchange shall promptly transmit any such filed qualified health plan rate to the Exchange. At the request of the Exchange, the Office shall consider the comments of the Exchange with respect to the approval or disapproval of the qualified health plan rate. The Office shall promptly transmit to the Exchange the approved rate of a qualified health plan, together with data concerning the rate filed by the issuer. The Commissioner's approval of a qualified health plan rate or premium shall constitute approval of the rate and premium for a qualified health plan, but shall not constitute certification on behalf of the Exchange with respect to any other aspect of the plan.

**Section 6. Filing of Health Insurance Plan Rates – Annual, All Market Filing in the Individual, Small Group, and Large Group Markets**

(a) The requirements of this Section shall apply to comprehensive hospital and medical health insurance plan rate filings in the individual, small group, and large group markets, in addition to the requirements of Section 5.

(b) On the date prescribed by the Commissioner, after at least 30 days' notice to affected health insurance issuers, each health insurance issuer doing business in this state with at least one percent of the covered lives in the insured market during the prior calendar year shall file its proposed rates for health insurance plans offered, issued or renewed during the succeeding calendar year for the individual, small group, and large group markets, including rates for individual and SHOP qualified health plans offered or proposed to be offered on the Exchange.

(c) In addition to the filing instructions authorized by the Commissioner under Section 5(e), the Commissioner's instructions for the annual, all market rate filing may require:

(1) a rate factor template completed on the form prescribed by the Commissioner;

(2) evidence of compliance with the affordability standards adopted by the Commissioner, in a manner prescribed by the Commissioner; and

(3) such other instructions as the Commissioner determines are necessary or desirable to review the rate filing in accordance with statutory and regulatory standards.

(d) The annual, all market rate filing provided for in this section shall not be considered complete until the health insurance issuer has responded to all additional requests by the Office for clarification of the filing, and the Office has notified the issuer that the filing is complete.

**Section 7. Commissioner's Review and Decision - Rates, Rating Formulas, and Rate Manuals**

(a) The provisions of this Section apply to rates, rating formulas, and rate manuals filed under Sections 5 and 6.

(b)(1) The Commissioner shall review the rate, rating formula, or rate manual filing and either (i) approve the filing, (ii) propose to the health insurance issuer how the filing can amended and approved, or (iii) notice an administrative hearing.

(2) If the Commissioner proposes amendments to the filing, the health insurance issuer shall be provided with an opportunity to amend its filing in conformity with the proposed amendments. If the health insurance issuer amends its filing in conformity with the proposed amendments, the Commissioner shall approve the filing.

(3) If the health insurance issuer does not amend its filing within the time period prescribed by the Commissioner, the Commissioner shall notice an administrative hearing on the filing.

(4) Notwithstanding the foregoing, after the Commissioner has determined a filing to be complete in connection with an individual health insurance plan rate, rating formula, or rate manual filing of a hospital or medical services corporation, including a rate, rating formula, or rate manual of a hospital or medical services corporation filed in connection with a qualified health plan, the Commissioner shall conduct an administrative hearing.

(c) Administrative hearings shall be conducted in accordance with R.I. Gen. Laws Title 42, chapter 35 (Administrative Procedures), R.I. Gen. Laws §§ 27-19-6, 27-20-6, 42-62-13, and any orders as to the conduct of the hearing issued by the Commissioner, or the Commissioner's designee.

(d) The Commissioner may approve, disapprove, or modify the rates, rating formula, or rating manual filed by the Issuer. A health insurance rate, rating formula, or rate manual shall not be approved unless the Commissioner determines that the health insurance issuer has demonstrated to the satisfaction of the Commissioner that it is consistent with the proper conduct of the business of the issuer, and consistent with the interests of the public. A health insurance rate, rating formula, or rate manual shall not be considered consistent with the proper conduct of the business of the issuer, and consistent with the interests of the public unless it is also consistent with the legislative purposes of the Office of the Health Insurance Commissioner under R.I. Gen. Laws § 42-14.5-2, and any regulations adopted by the Commissioner to carry out such legislative purposes. A rate, rating formula, or rate manual also shall not be considered to be consistent with the public interest if it fails to comply with the Commissioner's filing instructions.

(e) In connection with the Commissioner's approval of a health insurance plan rate, rating formula or rate manual, the Commissioner may attach to the decision such conditions as the Commissioner determines are necessary for the rate, rating formula, or rate manual to be consistent with the proper conduct of the issuer's business, consistent with the public interest, and consistent with the requirements of the laws and regulations applicable to health insurance rates, rating formulas, and rate manuals. Such conditions may include issuer obligations relating to:

(1) affordability standards adopted by the Commissioner, including hospital contracting conditions adopted by the Commissioner;

(2) issuer participation in a risk adjustment program or a reinsurance program administered by the Office in connection with health insurance plans;

(3) in connection with qualified health plans, compliance with the federal requirement concerning non-variability of premiums by geographic area; and

(4) Any other necessary and proper condition.

(f) A health insurance issuer may appeal the final decision of the Commissioner in accordance with R.I. Gen. Laws § 42-35-15.

**Section 8. 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 9. 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 construed to limit the powers granted the Commissioner by other provisions of law or regulation.

(c) This regulation shall not be construed to limit the powers of the Exchange to grant or revoke final certification of qualified health plans in its discretion in accordance with 45 C.F.R. § 155.1000 et seq., and subject to the provisions of Section 4(f) and Section 5(f) of this Regulation.

**Section 10. Effective Date**

This Regulation, and any amendments thereto, shall be effective on the date indicated below, and shall apply to decisions made or actions taken by the Commissioner on and after the effective date of this Regulation and its amendments.

EFFECTIVE DATE: January ___, 2012.