CONCISE EXPLANATORY STATEMENT

In accordance with the Administrative Procedures Act, R.I. Gen. Laws § 42-35-2.6, the following is a concise explanatory statement:

AGENCY: Department of Administration (DOA)

DIVISION: HealthSource RI (HSRI)

RULE IDENTIFIER: Part 220-RICR-90-00-2

RULE TITLE: Rules and Regulations Pertaining to the Rhode Island Reinsurance Program

REASON FOR RULEMAKING: The Rules and Regulations Pertaining to the Rhode Island Reinsurance Program are being adopted in accordance with R.I. Gen. Laws Chapter 42-157.1, which authorizes the Director of the Rhode Island Health Benefits Exchange (“Director”) to establish the Rhode Island Reinsurance Program (“Program”). These rules and regulations will, in part, govern the information issuers are required to submit to the Program, specify how reinsurance payment parameters will be determined and reinsurance payments made, establish the duties of the administrator, and provide for document retention requirements and program oversight.

TESTIMONY AND COMMENTS:

Summary of comments received:

2.3 Definitions:

11: Reinsurance eligible claim. We recommend that the director propose more detailed specifications on when claims are incurred for purposes of the definition of "reinsurance eligible claim." For example, if an inpatient hospital stay extends across multiple benefit years, it is not clear from the definition as it is currently proposed whether the date the claim is incurred should be determined based on the admission date or the discharge date.

RESPONSE: Comment generally accepted and 2.3(11) amended accordingly.

12: Reinsurance eligible health benefit plan. We recommend that the phrase "on or off exchange" be added after "individual market" in the first sentence of the definition. This

change will align the regulation with the intent of the statute, which states that "[t]he
program is intended to mitigate the impact of high-risk individuals on health insurance
rates offered in the individual insurance market on and off of the exchange."

RESPONSE: Comment generally accepted and 2.3(12) amended to clarify that the individual market includes plans offered on or off exchange.

2.4 Information Reporting
As a general comment on the information reporting requirements, we note that a member may change plans multiple times during a year, resulting in multiple member identification numbers and multiple HIOS identification numbers during a year for a single member. We understood the statute to be intending to roll up all claims for a single member for a year to determine whether and how much an issuer would be entitled to as a reinsurance payment for that member, and our requested rates were based on that assumption. As proposed, however, the reporting requirements may result in claims for a single member in a year being broken up into several pieces, by member or HIOS identification number, which may not show a reinsurance payment is required. We provide more specific comments below, but we recommend that the reporting requirements be revised to ensure that all claims for a single member in a benefit year will be consolidated for purposes of calculating reinsurance payments, regardless of the plan in which the member is enrolled.

RESPONSE: See specific responses below. Under 2.4(A)(3)-(4), issuers will be responsible for providing the director with the total amount of the reinsurance eligible issuer's reinsurance eligible claims for the benefit year, as well as the total reinsurance eligible claims for the benefit year that fall between the attachment point and reinsurance cap. Accordingly, a change is not required to ensure that all claims for a single member in a benefit year are consolidated for purposes of calculating reinsurance payments.

(A)(5): We recommend that the director propose detailed technical specifications and
instructions for the summary data files described in this section for at least a 30 day public comment period. As issuers may need time to implement changes to support these reporting requirements, we recommend these detailed specifications be proposed as soon as possible.

RESPONSE: This request for detailed technical specifications is beyond the scope of these regulations and no change is necessary. The director will consider this comment in the larger context of implementing the Program.

(A)(5)(a) We recommend that the regulation be revised to require that carriers provide a

unique carrier assigned identification number in the summary report rather than member
identification number in order to protect the member's privacy. Using a unique identifier
rather than member identification number would also allow claims to be consolidated for
individuals who may have more than one member identification number during a benefit
year due to plan changes.

RESPONSE: Comment generally accepted and 2.4(A)(5)(a) is amended accordingly. Reinsurance eligible issuers must ensure that they are readily able to identify the reinsurance eligible individual associated with the assigned identification number and provide that individual's identifying information to the director upon request.

(A)(5)(b) We recommend that the director propose additional detail on how issuers
should report the start and end date of coverage for members who may have multiple
effective dates during a year due to changes in plans, demographics, and gaps in
coverage.

RESPONSE: The requested additional detail will be provided through guidance to issuers. This recommendation is beyond the scope of these regulations and no change is necessary.

(A)(5)(c) We recommend that as part of the more detailed technical specifications and
instructions, the director ensures that the claims for a member with multiple HIOS Plan
IDs during the benefit year all roll up to the member for the purpose of determining any
reinsurance payment.

RESPONSE: This request for detailed technical specifications is beyond the scope of these regulations and no change is necessary. The Director will consider this recommendation in the larger context of Program implementation. Under 2.4(A)(3)-(4), issuers will be responsible for providing the director with the total amount of the reinsurance eligible issuer's reinsurance eligible claims for the benefit year, as well as the total reinsurance eligible claims for the benefit year that fall between the attachment point and reinsurance cap.

2.6 Reinsurance Payment:

(B)(I) We recommend deleting the"+" from the second line of this bullet.

RESPONSE: Comment accepted and 2.6 amended accordingly.

CHANGES TO TEXT OF THE RULE:

2.3(11) – Corrected typographical error.

2.3(11) – Added language clarifying that if a single reinsurance eligible claim for inpatient services spans multiple consecutive dates of service and extends across benefit years, the reinsurance eligible claim is deemed incurred on the discharge date.

2.3(12) – Added language clarifying that "reinsurance eligible health benefit plans" may be offered on exchange or off exchange.

2.4(A)(5)(a) – Added language that will require an issuer to provide a unique, issuer-assigned ID number rather than the member ID number in order to protect privacy.

2.4(C) – Added language requiring that an issuer ensure the unique, issuer-assigned ID number is traceable to the specific individual, and that the issuer provide that individual's identifiable information when requested by the director in order to safeguard program integrity.

2.6(B)(1) - Corrected typographical error.

REGULATORY ANALYSIS:

I. Introduction

The Director of the Rhode Island Health Benefits Exchange ("Director") proposes to adopt regulations governing the Rhode Island Reinsurance Program ("Program") established by the Director pursuant to the Rhode Island Market Stability and Reinsurance Act, R.I. Gen. Laws § 42-157.1-3 ("Act"), for the purposes of stabilizing health insurance rates and premiums in the individual market and providing greater financial certainty to consumers of health insurance in Rhode Island. Pursuant to the Administrative Procedures Act, R.I. Gen. Laws § 42-35-2.9 (APA), the Director has conducted a regulatory analysis for the proposed regulation. The Director used the best available information at the time of publication to estimate the benefits and costs of the proposed regulatory provisions. The following analysis examines the costs and benefits of a reasonable range of regulatory alternatives reflecting the scope of discretion provided by the Act.

II. Analysis of Regulatory Alternatives
a. § 2.4 Information Reporting

These proposed regulations would require health insurance carriers to provide the following information to the Program:

1. The name and company code assigned to the reinsurance eligible issuer by the National Association of Insurance Commissioners;

2. The identification number assigned to the reinsurance eligible issuer by the Health Insurance Oversight System (HIOS);

3. The total amount of the reinsurance eligible issuer’s reinsurance eligible claims for the benefit year;

4. The portion of the reinsurance eligible issuer’s total reinsurance eligible claims for the benefit year that fall between the attachment point and reinsurance cap;

5. A summary data file containing the following information for each reinsurance eligible individual with claims for which reinsurance payments are being requested:

    a. The member identification number assigned by the reinsurance eligible issuer to the reinsurance eligible individual;

    b. The start and end dates of coverage for the reinsurance eligible individual;

    c. The HIOS plan identification number for the reinsurance eligible health benefit plan in which the reinsurance eligible individual was enrolled;

    d. The total amount of reinsurance eligible claims for the reinsurance eligible individual for the benefit year; and

    e. The total amount of reinsurance eligible claims for the reinsurance eligible individual for the benefit year that fall between the attachment point and reinsurance cap.

6. If requested by the director, in conjunction with the final year-end report or an audit, a detailed claims file extracted from the reinsurance eligible issuer's claims processing system that includes the issuer's complete record of all reinsurance eligible claims for the benefit year.

7. An attestation signed by an executive officer of the reinsurance eligible issuer stating that the information is accurate as of the date of submission; and

8. Any other information requested by the director that he or she deems necessary to administer the program.

Data reporting from health insurance carriers is essential to the Program. The Program may use up to three carrier reports per Program year to 1) check progress on the Program, 2) set parameters for upcoming Program years, and 3) make payouts to carriers. These payouts will enable health insurance carriers to reduce average premiums in the individual market by an estimated 5-7% in the first year, equivalent to $12.3-$17.1 million in total premium savings. These reduced premiums will improve the affordability of health coverage, particularly for consumers who do not receive financial assistance towards the cost of coverage.

The Director estimates the first report would require 5-20 hours of work on the part of the carriers by someone in a data analyst role. Each subsequent report, up to three total per year, would require only small modifications, so the Director estimates the annual effort to be 15-30 hours. With two health insurance carriers presently participating in the individual market, the total effort across both is 30-60 hours. Assuming an hourly rate of $36 for a data analyst, the total estimated cost is $1,080-$2,160 per year. This data reporting requirement would not require a change to normal daily operations of the health insurance carrier.

An alternative to the reporting requirement proposed is to require quarterly interim reports and to have all reports include detailed claims information, rather than requiring that detail only be included once with the final report or an audit and upon request. The Director estimates this alternative would require 30-60 hours for each of the two health insurance carriers. At an hourly rate of $36 for a data analyst, the total estimated cost is $2,160-4,320 per year. The benefits of this alternative would be increased knowledge of Program progress as the year

progresses, as well as increased ability for the Director to review accuracy of data at the claims level. However, because of the cumulative nature of the Program over the year, multiple partial year reports are unlikely to provide significant additional value in assessing Program progress. The additional level of detail in interim reports also would not provide significant value because those reports would not be used to calculate final payments to carriers.

Another alternative to the reporting requirement would be to only require one annual report, and for it to omit claims and person-level data. The Director estimates this alternative would require 5-15 hours for each of the two health insurance carriers. At an hourly rate of $36 for a data analyst, the total estimated cost would be $360-$1,080 per year. While the cost is lower, the benefits of this alternative are also fewer. Payouts would still be made to carriers, but the lack of interim reports would mean that there would be no way to tell in advance if claims to date are higher or lower than expected. If no interim report were available to form the basis of future year's parameters, the Program would be using data that will be multiple years out of date as compared to the upcoming Program year. This could significantly increase the risks for health insurance carriers of a shortfall in funding. The lack of detail on reports would make it difficult for the Director to assess the validity of the data, and potentially increase the risk of fraud or otherwise inaccurate payments.

b. § 2.5 Reinsurance Parameters

This section clarifies that the Director will set the reinsurance payment parameters on an annual basis. Setting the reinsurance payment parameters on an annual basis using recent data will help ensure that the reinsurance payment parameters are as accurate as possible for the upcoming Program year. The Director will be able to receive the interim report and quickly determine parameters well in advance of the health insurance carriers' deadline to file plans and rates. This approach minimizes the uncertainty associated with the Program. If parameters were set on a less frequent basis, it would create more uncertainty in the market than if they were set annually. This increased uncertainty would be counter to the Act's purpose, which is, to authorize the Director to create the Program to stabilize

health insurance rates and premiums in the individual market and to provide greater financial certainty to consumers of health insurance in Rhode Island.

c. § 2.6 Reinsurance Payments

The adjustability of the coinsurance rate is critical to maximizing premium reductions for individuals purchasing health insurance plans. The Director's ability to adjust the coinsurance rate after receiving final claims data and revenue collection protects against overspending in a way that the alternative does not. The Director is prohibited by statute from allocating more resources than are available, necessitating either flexibility or conservative program design. A fixed system would require HSRI to be unnecessarily conservative resulting in a reduction in federal funds in to the state.

A fixed coinsurance rate, without the possibility of adjustment, could be set annually. Since the Program is funded by annual restricted receipts and federal funds and cannot draw from general revenues, a conservative Program design approach would be necessary to ensure that the parameters project payments totaling less than the estimated available funding. For example, if anticipated revenue after administrative costs is $8.3 million in state funds, the Program would have to set aside as much as half of that as a reserve to guard against worst case scenarios. While this approach increases certainty for carriers, it would result in a reduced Program size, in part due to reduced federal funding from pass-through savings. Given the funding reductions, the total Program impact would likely only be a 2-4% reduction to premiums.

The difference in risk assessment assumptions made by carriers (which impact funding levels) can be represented by the total expected statewide impact of the Program. Table 1[1] shows the estimated statewide reduction in individual health plan premiums for the first year of the program.

Table 1. Expected Benefits of Coinsurance Alternatives

Alternative	Rate Reduction	Total Expected 2020 Premiums Savings (Statewide)

1 These estimates were a result of forecasting a previous year's claims data and expected revenue from the newly instated Individual Mandate Penalty. Outyears forecasts were not included due to lack of data, annual funding, and program variability.

Adjustable Coinsurance Rate	5-7%	$12.3-17.1 million
Non-Adjustable Coinsurance Rate	2-4%	$4.9- 9.8 million

A unidirectional adjustability model was not deemed a viable alternative, as the development of parameters would closely mirror a non-adjustable framework, which is expected to reduce the benefit. Similarly, the adjustability of all or varying combinations of the parameters would afford health insurance carriers the least amount of certainty with no additional benefit beyond the adjustable coinsurance rate model.

d. § 2.7 Duties of the Director

Under the Director's delegation of authority under the Act, this section attempts to strike a balance between limiting the burden on health insurance carriers and the need to ensure effective operation of the Program. The Director will have the ability to conduct an audit of the information submitted under § 2.4. Without this authority, there would be a higher potential for program and financial integrity issues, including fraud and abuse.

To reduce the burden on carriers, this section also gives the director the ability to use, access, store and disclose the information under § 2.4, including disclosures to the Health Insurance Commissioner, for the efficient administration of the Program and to reduce the reporting burden on health insurance carriers. Under the Act, health insurance carriers are required to submit the information outlined in § 2.4 to the Office of the Health Insurance Commissioner (OHIC) and the Exchange. In order to reduce the burden on health insurance carriers, the Director may disclose the information to OHIC rather than requiring health insurance carriers to do so. Alternatively, the Director could have required health insurance carriers to provide the information directly to OHIC which would have resulted in an increased burden on carriers.

e. § 2.8 Document Retention and Audits

Auditing the information submitted to the Program by health insurance carriers under § 2.4 is important to ensuring program integrity, oversight, and the appropriate expenditure of public funds. If health insurance carriers were not subject to audit, there would be a higher potential for program integrity issues. This regulation would require health insurance carriers to submit a corrective action plan in the event an audit results in a finding of material weakness or significant deficiency.

If the Director determines that a health insurance carrier received excess reinsurance payments during the course of an audit, the health insurance carrier will be required to return the excess payments to the Program at the request of the Director within 30 days of that request. Health insurance carriers are only permitted to receive reinsurance payments that they are eligible for, as set forth in the proposed regulation, so if a health insurance carrier receives excess payments, it is important for the Director to have the ability to require return of those excess payments. Alternatively, if this provision were omitted from the regulation, there would be less certainty about how excess payment disputes are resolved, and a higher risk that health insurance carriers are unjustly enriched.

III. Determinations

Upon review of all the costs and benefits, the Director has determined that the benefits of the proposed rule justify the costs of the proposed rule. Further, the proposed rule will achieve the objectives of the authorizing statute in a more cost-effective manner, or with greater benefits, than other regulatory alternatives.

IV. Supporting Documentation

United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, *available at* https://www.bls.gov/ooh/

Rhode Island's 1332 Waiver Application, July 8, 2019, *available at*: https://healthsourceri.com/wp-content/uploads/190708_FinalApplicationPackage.pdf