220-RICR-90-00-2

TITLE 220 - DEPARTMENT OF ADMINISTRATION

CHAPTER 90 – HEALTH BENEFITS EXCHANGE

SUBCHAPTER 00 – N/A

PART 2 – Rules and Regulations Pertaining to the Rhode Island Reinsurance Program

2.1 Purpose

A. The purpose of these Regulations is to establish certain rules governing the Rhode Island Reinsurance Program established by the Director pursuant to R.I. Gen. Laws § 42-157.1-3 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 the state.

B. Additional Guidance

1. Policies and procedures for implementation of these regulations may be established in manuals and other documents by the Director.

C. Relation to Other Laws

1. Nothing in these regulations shall preempt or otherwise conflict with any applicable state and federal laws and rules.

2.2 Authority

A. This regulation is promulgated pursuant to the authority granted in R.I. Gen. Laws § 42-157.1-4.

B. Pursuant to the provisions of R.I. Gen. Laws §§ 42-35-3(a)(3) and 42-35.1-4, consideration was given to: alternative approaches to the regulations; duplication or overlap with other state regulations; and significant economic impact on small business.

C. Based upon available information, no known alternative approach, duplication or overlap was identified.

2.3 Definitions

A. The following definitions shall apply to this regulation:

1. "Attachment point" means the threshold dollar amount, adopted by the Director, after which point the claims costs of an insured individual's covered benefits under a reinsurance-eligible health benefit plan in a benefit year are eligible for reinsurance payments.

2. "Benefit year" means a calendar year beginning on or after January 1, 2020, for which a reinsurance eligible health benefit plan provides health insurance coverage.

3. "Coinsurance rate" means the rate at which the Director may reimburse a reinsurance eligible health benefit plan for claims costs incurred after the attachment point and before the reinsurance cap for an insured individual's covered benefits in a benefit year. The coinsurance rate is set by the Director at an initial estimated value but is subject to change in accordance with § 2.6(B)(2) of this Part.

4. "Director" means the Director of the Rhode Island health benefit exchange, or his/her designee(s).

5. "Health insurance carrier" or "carrier" means the same as it does in R.I. Gen. Laws § 27-18.5-2.

6. "Health insurance coverage" means the same as it does in R.I. Gen. Laws § 27-18.5-2.

7. "Individual market" means the same as it does in R.I. Gen. Laws § 27-18.5-2.

8. "Program" means the Rhode Island reinsurance program established by the Director pursuant to R.I. Gen. Laws § 42-157.1-3.

9. "Regulations" means all parts of the Rules and Regulations Pertaining to the Rhode Island Reinsurance Program.

10. "Reinsurance cap" means the threshold dollar amount, adopted by the Director, for claims costs incurred by a reinsurance eligible health benefit plan for an insured individual's covered benefits in a benefit year, after which threshold the claims costs for the benefits are no longer eligible for reinsurance payments.

11. "Reinsurance eligible claim" means a claim for services covered under a reinsurance eligible health benefit plan that is incurred by a reinsurance eligible issuer during the applicable benefit year and within the period of eligibility for the member, that is paid by the reinsurance eligible issuer before June 1 of the following year. A reinsurance eligible claim shall not

be adjusted for risk nor for pharmacy rebates. A reinsurance eligible claim does not include a claim for certain abortion services, as defined in 45 C.F.R. § 156.280(d)(1). In the event 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.

12. "Reinsurance eligible health benefit plan" means health insurance coverage offered on the individual market, irrespective of whether it is offered through the Rhode Island health benefit exchange, that:

    a. constitutes minimum essential coverage, as set forth in 26 U.S. C. § 5000A(f);

    b. is approved by the state's health insurance commissioner;

    c. is delivered or issued for delivery by a carrier in the state; and

    d. is not a grandfathered health plan as defined in §1251 of the Patient Protection and Affordable Care Act.

13. "Reinsurance eligible individual" means an individual who is insured in a reinsurance eligible health benefit plan on or after January 1, 2020.

14. "Reinsurance eligible issuer" means a health insurance carrier that offers a reinsurance eligible health benefit plan to reinsurance eligible individuals.

15. "Reinsurance payment" means payments issued to a reinsurance eligible issuer in accordance with § 2.6 of this Part.

16. "State" means the State of Rhode Island.

2.4 Information Reporting

A. As a condition of receiving reinsurance payments from the program, a reinsurance eligible issuer must provide the following information to the program in the form and manner prescribed by the Director:

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. An 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.

B. As a condition of receiving reinsurance payments from the program, a reinsurance eligible issuer must submit the information required under § 2.4(A) of this Part to the program:

1. Using a secure method of transmission approved by the Director; and

2. On the following timeframes:

   a. Upon request, one interim report during the benefit year for the purposes of estimating reinsurance payments;

   b. One interim report due on February 15th after the benefit year, containing data from the prior benefit year with claims paid by January 31st, and an estimate of claims payments still outstanding. This report will be used to aid the Director in setting parameters for future program years; and

   c. One final report due June 30th after the benefit year, containing all reinsurance eligible claims incurred during the prior benefit year and paid by June 1st for the purposes of calculating final reinsurance payments to carriers.

C. A reinsurance eligible issuer shall ensure that it is able to readily identify the reinsurance eligible individual associated with the identification number it assigns under § 2.4(A)(5)(a) of this Part and shall provide this identifying information to the Director upon request.

2.5 Reinsurance Parameters

A. Annually, the Director will set an attachment point, cap, and coinsurance rate for the reinsurance program for the upcoming year based on anticipated revenue and recently reported premium, enrollment, and claims data.

2.6 Reinsurance Payments

A. A reinsurance eligible issuer becomes eligible for a reinsurance payment when the claims costs for at least one reinsurance eligible individual's covered benefits in a calendar year exceed the attachment point.

B. The Director will calculate the total reinsurance payment owed to each reinsurance eligible issuer.

   1. Subject to §§ 2.6(B)(2) and 2.6(B)(3) of this Part, the reinsurance payment made to each reinsurance eligible issuer for a benefit year will be the product of the coinsurance rate and the portion of the reinsurance eligible issuer’s total reinsurance eligible claims for the benefit year that fall between the attachment point and the reinsurance cap.

   2. The Director will uniformly reduce or increase the coinsurance rate to the extent necessary, but at no time shall the increase exceed 100%, to

ensure that reinsurance payments equal the total available funding for the benefit year, as determined by the Director in his or her sole discretion.

3. In making the calculation under § 2.6(B)(1) of this Part, the Director in his or her sole discretion may disregard any or all reinsurance eligible claims reported by a reinsurance eligible issuer under § 2.4 of this Part that cannot be verified as part of the audit described under § 2.7(A)(1) of this Part.

C. The program will issue reinsurance payments to all reinsurance eligible issuers on an annual basis in the year following each benefit year.

D. Payments will be made directly to reinsurance eligible issuers by a method designated by the Director.

E. The program will not issue reinsurance payments if the Director determines that a reinsurance eligible issuer has substantively failed to comply with this Part.

2.7 Duties of the Administrator

A. The program shall be administered by the Director. As administrator of the program, the Director may:

1. Conduct an audit of the information submitted under § 2.4 of this Part.

2. Notify reinsurance eligible issuers of the results of the calculation described in § 2.6 of this Part, including any modifications of the coinsurance rate.

3. Issue reinsurance payments to each reinsurance eligible issuer in accordance with § 2.6 of this Part.

4. Assign the functions vested in him or her by the Rhode Island Market Stability and Reinsurance Act and these regulations to subordinate officers and employees as he or she deems necessary. The assignee shall have the same power and authority that would be afforded the Director.

5. Contract with other state agencies and third parties as he or she deems necessary.

6. Use, access, store, and disclose the information submitted to the program under § 2.4 of this Part, including disclosing the information to the Office of the Health Insurance Commissioner for the purposes of ensuring the

efficient administration of the program and to reduce the reporting burden on issuers.

7. Perform other functions he or she deems reasonably necessary to administer the program.

2.8 Document Retention and Audits

A. A reinsurance eligible issuer must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate its requests for reinsurance payments made pursuant to this Part for a minimum period of 10 years and must make those documents and records available to the program upon request by the Director for purposes of verification, investigation, or audit.

B. The Director may audit a reinsurance eligible issuer to assess its compliance with the requirements of this Part. The reinsurance eligible issuer must ensure that its relevant contractors, subcontractors, or agents cooperate with any audit under this Part. If an audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement of this Part, the reinsurance eligible issuer must complete all of the following:

1. Within 30 calendar days of the issuance of the final audit report, provide a written corrective action plan to the program for approval;

2. Implement that plan; and

3. Provide to the program written documentation of the corrective actions once taken.

C. If, at the conclusion of an audit, the Director determines that a reinsurance eligible issuer received excess reinsurance payments, at the request of the Director the reinsurance eligible issuer shall return the excess payments to the program in a manner to be determined by the Director within 30 days of his or her request.

2.9 Severability

A. If any provisions of this Part or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

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