220-RICR-90-00-1

TITLE 220 – DEPARTMENT OF ADMINISTRATION

CHAPTER 90 – HEALTH BENEFITS EXCHANGE

SUBCHAPTER 00 – N/A

PART 1 – Rules and Regulations Pertaining to HealthSource RI

1.1 Purpose

A. The purpose of these Regulations is to establish certain rules governing:

1. Individual eligibility for enrollment in a Qualified Health Plan;

2. Individual eligibility for receipt of advance payments of the premium tax credit and cost sharing reductions;

3. Enrollment of qualified individuals in a Qualified Health Plan;

4. Initial open enrollment, annual open enrollment and special enrollment periods for qualified individuals;

5. Premium payments and termination of coverage for qualified individuals;

6. Eligibility for Minimum Essential Coverage exemptions;

7. The operation of a SHOP Exchange, including enrollment of qualified employers and qualified employees into qualified health plans;

8. A mechanism for handling all Rhode Island Health Benefits Exchange Appeals; and

9. Establishment of a trust to facilitate the collection and payment of premiums to qualified health plan issuers and the receipt of payments for such products and services as may be offered by and/or through the Exchange related to the goals of improving the health, wellbeing and outcomes of all Rhode Islanders.

B. Exchange Functions

1. The Exchange carries out the functions described in 45 C.F.R. Part 155, incorporated below at § 1.3 of this Part.

C. Additional Guidance

1. Policies and procedures for implementation of these Regulations may be established in manuals and other documents promulgated by the Exchange.

D. Relation to Other Laws

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

1.2 Authority

A. This Part, titled “Rules and Regulations Pertaining to HealthSource RI”, is promulgated pursuant to the authority set forth in R.I. Gen. Laws Chapter 42-157; the Patient Protection and Affordable Care Act (U.S. Pub. Law 111-148) (ACA), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (U.S. Pub. Law 111-152), and any amendments to, or regulations or guidance issued under those acts.

B. § 1311 of the ACA provides legal authority for states to establish health insurance exchanges. Health insurance exchanges are designed to provide affordable health insurance to eligible individuals and small businesses through Qualified Health Plans (QHPs). The Exchange will operate a Small Business Health Options Program (SHOP), which permits employers to obtain group health insurance coverage for their employees. Certain employers that purchase coverage through a SHOP are eligible for a federal small business premium tax credit.

C. 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.

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

1.3 Incorporated Materials

These regulations hereby adopt and incorporate 45 C.F.R. Parts 155, 156 and 157 (2018) and 26 C.F.R. § 1.36B (2018) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

1.4 Definitions

A. Wherever used in this Part, the following terms shall be construed as follows:

1. "Act" or "ACA" means the federal Patient Protection and Affordable Care Act (U.S. Pub. Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (U.S. Pub. Law 111-152), and all rules promulgated thereunder.

2. "Advance payments of the premium tax credit" or "APTCs" means payments of the tax credits specified in 26 U.S.C. § 36B which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through the Exchange.

3. "Annual open enrollment period" means the period during which a qualified individual may enroll in coverage through the Exchange for an upcoming Benefit Year.

4. "Applicant" means an individual who is seeking eligibility for him or herself or for members of his or her household through an application submitted to the Exchange for at least one of the following:

   a. Enrollment in a Qualified Health Plan;

   b. Advance payments of the premium tax credit and cost sharing reductions; or

   c. Medicaid or CHIP, if applicable; or

   d. An employer or employee seeking eligibility for enrollment in a Qualified Health Plan through SHOP where applicable.

5. "Benefit year" means a calendar year for which a health plan provides coverage for health benefits.

6. "Cost sharing reductions" or "CSRs" means reductions in cost sharing for an eligible individual enrolled in a silver level plan, as defined by § 1302(d)(1)(B) of the ACA, in the Exchange or for an individual who is an Indian enrolled in a Qualified Health Plan through the Exchange.

7. "Dependent" means any individual who is or who may become eligible for coverage under the terms of a Qualified Health Plan because of a relationship to a qualified individual or enrollee.

8. “Eligibility appeals” means appeals from an eligibility decision made by the Exchange in accordance with 45 C.F.R. § 155.505, incorporated above at § 1.3 of this Part, including:

    a. An initial determination of eligibility, including the amount of APTCs and the level of CSRs, made in accordance with standards specified in 45 C.F.R. §§ 155.305(a) through (h), incorporated above at § 1.3 of this Part;

    b. A redetermination of eligibility, including the amount of APTCs and level of CSRs, made in accordance with 45 C.F.R. §§ 155.330 and 155.335, incorporated above at § 1.3 of this Part;

    c. The failure by the Exchange to make such eligibility determination or redetermination in a timely manner; and

    d. A termination from QHP coverage or disenrollment from a QHP made by the Exchange in accordance with 45 C.F.R. § 155.430, incorporated above at § 1.3 of this Part.

9. “Enrollee” means a qualified individual or qualified employee enrolled in a QHP.

10. “EOHHS” means the Rhode Island Executive Office of Health and Human Services.

11. “Exchange” means the Rhode Island Health Benefits Exchange, doing business as HealthSource RI.

12. “Exchange appeals” means Eligibility Appeals, Exemption Appeals, Large Employer Appeals, and SHOP Appeals, as defined in these Regulations.

13. “Exemption appeals” means appeals from a determination of eligibility for an exemption from the Individual Responsibility Penalty (IRP) made by the Exchange in accordance with § 1311(d)(4)(H) of the ACA.

14. “Federal regulations” means the regulations promulgated under the Act at 45 C.F.R. Parts 155, 156 and 157, incorporated above at § 1.3 of this Part.

15. “FPL” means the most recently published federal poverty level guidelines available as of the first day of the annual open enrollment period for coverage offered through the Exchange.

16. “HHS” means the U.S. Department of Health and Human Services.

17. “Indian” has the same meaning as the definition of Indian given in 45 C.F.R. § 155.300, incorporated above at § 1.3 of this Part.

18. “Individual responsibility penalty” means the tax penalty associated with the failure of certain individuals to carry minimum essential coverage in accordance with § 5000A of the Internal Revenue Code (26 U.S.C. § 5000A).

19. “Issuer agreement” means the agreement between the QHP issuer and the Exchange that satisfies all applicable requirements of the federal regulations.

20. “Large employer appeals” means appeals from a determination that an employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable with respect to an employee, as further set forth in 45 C.F.R. § 155.555, incorporated above at § 1.3 of this Part.

21. “Lawfully present” has the same meaning given to the term in 45 C.F.R. § 155.305, incorporated above at § 1.3 of this Part.

22. “Limited cost sharing plan” means, with respect to a QHP at any level of coverage, the variation of such QHP described in 45 C.F.R. § 156.420(b)(2), incorporated above at § 1.3 of this Part.

23. “Premium” means the payment required to be paid for an enrollee to participate in a Qualified Health Plan.

24. “Qualified employee” means an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP.

25. “Qualified employer” means an employer that is eligible to participate in the SHOP Exchange and elects to make available health coverage to its employees through the SHOP Exchange.

26. “Qualified health plan” or “QHP” means a health plan that has in effect a certification that it meets the standards described in 45 C.F.R. Part 156 Subpart C and such additional standards that may be prescribed, issued or recognized by the Exchange in accordance with the process described in 45 C.F.R. Part 155 Subpart K, incorporated above at § 1.3 of this Part.

27. “Qualified individual” means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a Qualified Health Plan in the individual market.

28. “R.I. Gen. Laws” means the General Laws of Rhode Island, as amended.

29. “SHOP appeals” means appeals by employers or employees of determinations of eligibility for the SHOP Exchange made by the Exchange in accordance with 45 C.F.R. § 155.715, incorporated above at § 1.3 of this Part, including the failure of the Exchange to make such eligibility determinations in a timely manner.

30. “SHOP exchange” means the Small Business Health Options Program in accordance with § 1311(b)(1)(B) of the ACA and 45 C.F.R. Part 155 Subpart H, incorporated above at § 1.3 of this Part, through which a qualified employer may provide its employees and their dependents participation in one or more QHPs.

31. “Special enrollment period” means a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a Qualified Health Plan through the Exchange outside of the initial and annual open enrollment periods

32. “Regulations” mean all parts of the Rules and Regulations Pertaining to HealthSource RI.

33. “Trust” means the HealthSource RI Trust established by the Exchange.

34. “Zero cost sharing plan” means, with respect to a QHP at any level of coverage, the variation of such QHP described in 45 C.F.R. § 156.420(b)(1), incorporated above at § 1.3 of this Part.

1.5 Qualified Health Plan Eligibility and Enrollment

A. In General - § 1311 of the ACA establishes exchanges to facilitate the purchase of qualified health plans. § 1311 and its implementing regulations, 45 C.F.R. § 155.305 and 45 C.F.R. § 155.400, incorporated above at § 1.3 of this Part, respectively, establish eligibility requirements and requirements for enrollment in a Qualified Health Plan.

B. Eligibility for Enrollment in a QHP through the Exchange - The Exchange shall determine an applicant eligible for enrollment in a Qualified Health Plan if he or she meets the requirements in 45 C.F.R. § 155.305, incorporated above at § 1.3 of this Part, including the following requirements:

1. Citizenship, status as a national, or lawful presence. Is a citizen, or national of the United States, or is a non-citizen who is lawfully present in the United States and is reasonably expected to be a citizen, national or a

non-citizen who is lawfully present for the entire period for which enrollment is sought;

2. Incarceration. Is not incarcerated, other than incarceration pending the disposition of charges;

3. Residency. Meets the applicable residency standards as defined in 45 C.F.R. § 155.305 (a)(3), incorporated above at § 1.3 of this Part.

C. QHP Selection - The Exchange shall accept a Qualified Health Plan selection from an applicant determined eligible for enrollment in a QHP. The Exchange shall notify the issuer of the applicant's selected QHP and transmit information necessary to enable the QHP issuer to enroll the applicant.

D. QHP Enrollment - Enrollment of a qualified individual in a QHP shall be limited to the annual open enrollment period, or a special enrollment period.

E. Appeals - An applicant has the right to an appeal of an eligibility determination pursuant to the appeals process as described in these Regulations and as may be set forth in 210-RICR-10-05-2.

1.6 Annual Open Enrollment and Special Enrollment Periods

A. In General - § 1311 of the ACA and its implementing regulations, 45 C.F.R. §§ 155.410 and 155.420, incorporated above at § 1.3 of this Part, establish requirements for annual open enrollment, and special enrollment periods for Qualified Health Plans.

B. Annual Open Enrollment Period.

1. The Exchange will establish the annual open enrollment period and shall provide a minimum of one hundred twenty (120) days advance public notice prior to its first day.

2. Annual Open Enrollment Periods as established by the Exchange shall last a minimum of thirty (30) days.

C. Annual Open Enrollment Period Coverage Effective Dates.

1. Qualified individuals must select a QHP and the Exchange must receive the first month's premium in full by the payment deadlines established by the Exchange in order to effectuate coverage.

2. The Exchange shall establish a deadline relative to the Annual Open Enrollment Period by which a qualified individual's first month's premium

must be received in order to make coverage effective as of the first day of the benefit year.

D. Special Enrollment Periods - The Exchange shall provide special enrollment periods consistent with 45 C.F.R. § 155.420, incorporated above at § 1.3 of this Part, during which qualified individuals may enroll in Qualified Health Plans and enrollees may change Qualified Health Plans.

1. Triggering Events.

a. The Exchange will allow a qualified individual or enrollee, and, when specified below, his or her dependent, to enroll in or change from one QHP to another if one of the triggering events defined in 45 C.F.R. § 155.420(d), incorporated above at § 1.3 of this Part, occurs. The Exchange shall also have the authority to define other triggering events not otherwise specified in 45 C.F.R. § 155.520(d), incorporated above at § 1.3 of this Part.

2. Effective Dates.

a. Except as specified in 45 C.F.R. §§ 155.420(b)(2) and (3), incorporated above at § 1.3 of this Part, the Exchange shall establish a monthly deadline by which a qualified individual enrolling during a Special Enrollment Period must select a QHP and the Exchange must receive the first month's premium in full by the payment deadlines established by the Exchange in order to make coverage effective on the first day of the following month. The Exchange shall make coverage effective on the first day of the second following month for a qualified individual not meeting the monthly deadline.

1.7 Eligibility and Special Rules on the Advanced Payments of the Premium Tax Credit and Cost Sharing Reductions

A. Advanced Payments of the Premium Tax Credit.

1. In General - § 1401 of the ACA creates new section 36B of the Internal Revenue Code (the Code, 26 U.S.C.), which provides for a premium tax credit for eligible individuals who enroll in a QHP through an Exchange. § 1402 of the ACA establishes provisions aimed at reducing the cost-sharing obligations of certain eligible individuals enrolled in a QHP offered through an Exchange, including standards for determining Indians eligible for certain categories of cost-sharing reductions. The ACA and its implementing regulations, found in 45 C.F.R. § 155.305, incorporated

above at § 1.3 of this Part, authorize the Exchange to determine qualified individuals' eligibility for Advance Payments of the Premium Tax Credits. In order to qualify for Advance Payments of Premium Tax Credits, an applicant must meet both the eligibility requirements to enroll in a Qualified Health Plan as described at § 1.5 of this Part and the eligibility requirements for the advance payment of premium tax credits as described in this subpart and 45 C.F.R. § 155.305, incorporated above at § 1.3 of this Part. An applicant determined eligible for a premium assistance amount may elect not to take the full monthly premium assistance amount for which he or she is determined eligible. The amount of the premium tax credit the applicant should have received over the course of the benefit year will be reconciled when the applicant files a tax return for that year.

2. Eligibility for Advance Payments of the Premium Tax Credit - The Exchange shall find an applicant eligible for advance payments of the premium tax credit if the Exchange determines that he or she meets the criteria in 45 C.F.R. § 155.305, incorporated above at § 1.3 of this Part, including the following:

    a. He or she is expected to have a household income, as defined in section 36B(d)(2) of the Internal Revenue Code (26 U.S.C. § 36B(d)(2)), of greater than or equal to 100 percent of the FPL and less than 400 percent of the FPL for the benefit year for which coverage is requested; and

    b. He or she plans to file a federal tax return, and, if married, to file a joint return, for the benefit year;

    c. He or she may not be claimed by another tax filer as a tax dependent under Section 151 of the Internal Revenue Code (26 U.S.C. § 151).

3. Individuals for Whom a Premium Assistance Amount Can be Provided - An applicant will be eligible for a premium assistance amount only for a month that one or more members of the tax filer's family (the tax filer or the tax filer's spouse or tax dependent) meet the following criteria:

    a. Are enrolled in one or more QHPs; and

    b. Are not eligible for minimum essential coverage as defined in 26 C.F.R. § 1.36B-2(c), incorporated above at § 1.3 of this Part, other than individual market coverage described in 5000A(f)(1)(C) of the Internal Revenue Code (26 U.S.C. § 5000A(f)(1)(C)).

4. Special Rule for Non-Citizens Who are Lawfully Present Immigrants and Who Are Ineligible for Medicaid by Reason of Immigration Status - In accordance with 45 C.F.R. § 155.305(f)(2), incorporated above at § 1.3 of this Part, lawfully present immigrants who are ineligible for Medicaid based on immigration status and whose household income is below one hundred percent (100%) of the FPL shall be eligible for an APTC if they meet all other eligibility requirements for advance payments of the premium tax credit.

5. Calculation of Advance Payments of the Premium Tax Credit - The Exchange shall calculate any applicant's advance payment of the premium tax credit in accordance with the requirements of 26 C.F.R. § 1.36B-3, incorporated above at § 1.3 of this Part.

6. Appeals - An applicant has the right to an appeal of an eligibility determination based on this section and pursuant to the appeals process as described in § 1.14 of this Part and as set forth in 210-RICR-10-05-2, if applicable.

B. Cost Sharing Reductions

1. In General - § 1401 of the ACA and its implementing regulations, 45 C.F.R. § 155.305, incorporated above at § 1.3 of this Part, establish eligibility requirements for an applicant to receive cost sharing reductions. To receive cost sharing reductions, an applicant must meet the eligibility requirements to enroll in a Qualified Health Plan as described in § 1.5(B) of this Part, the eligibility requirements for the advance payments of a premium tax credit as described at § 1.7(A) of this Part, and the eligibility requirements as described in § 1.7(B) of this Part.

2. Eligibility Criteria - The Exchange will determine an applicant eligible for cost-sharing reduction if he or she:

   a. Is expected to have household income, as defined in 36B(d)(2) of the Internal Revenue Code (26 U.S.C. § 36B(d)(2)), that does not exceed two hundred and fifty percent (250%) of the FPL for the benefit year for which coverage is requested; and

   b. Meets the eligibility criteria for enrollment in a QHP; and

   c. Meets the eligibility criteria for an advance payment of a premium tax credit.

3. Provided Only to Enrollees in a Silver-Level Qualified Health Plan - With the exception of Indians, the Exchange will provide cost-sharing

reductions only to enrollees who enroll in a silver-level Qualified Health Plan as defined by § 1302(d)(1)(B) of the ACA.

4. Use of Eligibility Categories - The Exchange will use the CSR eligibility categories set forth in 45 C.F.R. § 155.305(g), incorporated above at § 1.3 of this Part.

5. Special Rule for Lawfully Present Immigrants Below 100% FPL - The Exchange will follow the federal rule set forth in 26 C.F.R. § 1.36B-2, incorporated above at § 1.3 of this Part, for lawfully present immigrants with income below one hundred percent (100%) FPL who are eligible for a cost-sharing reduction.

6. Special Rules for Indians - The Exchange will follow the special rules for Indians as set forth in 45 C.F.R. § 155.350, incorporated above at § 1.3 of this Part.

    a. The Exchange will find Indians with expected household income equal to or less than three hundred percent (300%) of the FPL, who are eligible for an APTC, and who enroll in a QHP, eligible for a zero cost-sharing plan.

    b. The Exchange will find Indians who apply for an insurance affordability program eligible for the limited cost-sharing plan regardless of their income level.

7. Special Rule for Multiple Tax Households - To the extent that enrollment in a QHP includes individuals who expect to be in different tax households, the Exchange will apply only the category of eligibility last listed below for which all the individuals covered by the policy would be eligible:

    a. No cost sharing reduction

    b. Limited cost-sharing reduction plan (for Indians)

    c. Category 3 cost-sharing reduction plan (for 201% FPL to 250% FPL)

    d. Category 2 cost-sharing reduction plan (for 151% FPL to 200% FPL)

    e. Category 1 cost-sharing reduction plan (for 100% FPL to 150% FPL)

    f. Zero cost-sharing reduction plan (for Indians below 301% FPL)

8. Appeals. An applicant has the right to an appeal of an eligibility determination based on this section and pursuant to the appeals process as described in § 1.14 of this Part and as set forth in 210-RICR-10-05-2, if applicable.

1.8 Application and Renewal Process

A. Integrated Eligibility System - In September 2016, the State of Rhode Island implemented its new integrated eligibility system (IES) which has the capacity to cross-walk with the agency that administers the State's Medicaid program, EOHHS, and, through a single application process, evaluate eligibility for QHP and publicly financed health coverage. This section focuses on the application and renewal processes that have been established in conjunction with the implementation of the IES.

B. Access Points - The State is committed to pursuing a "No Wrong Door" policy that offers individuals multiple application and renewal access points which all lead to the State's IES.

1. Self-Service – Individuals seeking initial or continuing eligibility have the option of accessing the eligibility system on-line using a self-service portal through links on the HealthSource RI (healthsourceri.com) Executive Office of Health and Human Services (eohhs.ri.gov) and Department of Human Services (dhs.ri.gov) websites.

2. Assisted Service – Individuals may also apply on paper and submit forms via mail to the address specified thereon or deliver in person to HealthSource RI's walk-in center.

3. Individuals may also visit the HealthSource RI walk-in center or contact the HealthSource RI contact center directly for assistance with an application.

C. Automatic Renewal Process - An individual enrolled in a QHP will receive notice prior to the end of each Benefit Year indicating whether their health insurance coverage can be automatically renewed for the following Benefit Year. If the individual's health insurance coverage can be automatically renewed, then the individual's notice will include the matched plan and estimated cost for the coverage. Individuals must make payment in full by the relevant payment deadlines, as established by the Exchange, for the health insurance plan to become effective in the new Benefit Year. If the individual/family misses the payment deadline for the first month of the upcoming Benefit Year, their application will be cancelled and coverage will not effectuate.

1. Notwithstanding the other provisions of this section, HealthSource RI will not automatically renew individuals such that coverage in their new plan, as compared to their existing plan, adds or eliminates comprehensive coverage for abortion services, as defined in 45 C.F.R. § 156.280(d)(1), which is incorporated above at § 1.3 of this Part. Individuals who are not automatically renewed as a result of this subsection will be sent a notice, in coordination with their annual open enrollment notice, that provides an explanation regarding the reason they have not been automatically renewed and detail the steps they will need to take in order to select a plan for the upcoming year. This notice will also provide a list of plans that do and do not cover comprehensive abortion services.

1.9 Applying for Coverage

A. In general, the process of completing and submitting an application proceeds in accordance with the following:

1. Account Creation - To initiate the application process, an individual must create a login and establish an account in the eligibility system. This can be done through the self-service portal by the person alone or with the help of an eligibility specialist or certified assister.

2. Identity proofing - The applicant must provide personally identifiable information for the purpose of creating an on-line account as a form of identify proofing during the process of applying for health coverage. Verification of this information is automated. Documentation proving identity may be required if the automated verification process is unsuccessful. Acceptable forms of identity proof include a driver's license, school registration, voter registration card, etc. Documents may be submitted via mail, on-line upload, or delivered to the HealthSource RI contact center.

3. Account matches - Once identity is verified, account matches are conducted to determine whether the applicant or members of the applicant's household have other accounts or are currently receiving benefits.

4. Application submission - An Individual must submit a signed and completed application in order to receive an eligibility determination for health coverage. All signatures required from an applicant to complete an application may be obtained electronically. Any such electronic signature is valid and the legal equivalent of a signature obtained in another form. To submit an application for health coverage, individuals must agree to the terms contained therein.

1.10 Termination of Coverage and Grace Periods

A. Termination of Coverage:

1. In General - § 1412(c)(2) of the ACA, and its implementing regulation, 45 C.F.R. § 156.270, incorporated above at § 1.3 of this Part, establish a three-month grace period for non-payment of premium before coverage will be terminated for a qualified individual who is receiving advance payment of premium tax credits and has made at least one full month's premium payment during the Benefit Year. 45 C.F.R § 155.430, incorporated above at § 1.3 of this Part, establishes procedures for termination of QHP coverage.

2. Termination of Coverage Due to Non-Payment of Premium - The Exchange shall establish a standard policy for the termination of coverage of enrollees due to non-payment of premiums. This policy for the termination of coverage:

   a. Must include the grace period for enrollees receiving advance payments of the premium tax credits; and

   b. Must be applied uniformly to enrollees in similar circumstances.

B. Grace Periods:

1. Individuals Receiving an Advance Premium Tax Credit - The Exchange shall provide a grace period of three consecutive months if an enrollee eligible to receive advance payments of the premium tax credit has previously paid at least one full month's premium during the Benefit Year.

2. Exhaustion of grace period - If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums, the Exchange shall terminate the enrollee's coverage. Coverage is terminated with retrospective effect to the last day of the first month of the 3-month grace period.

3. The QHP issuer must continue to pay claims during the first month of the grace period and may pend claims during the second and third months of the grace period.

4. The Exchange has the authority to extend a Grace Period on a case-by-case basis.

C. Qualified Health Plan Issuers May Not Terminate Coverage - If a Qualified Health Plan issuer believes coverage should be terminated, it must request a termination from the Exchange, in a manner prescribed by the Exchange.

D. Involuntary Termination - The Exchange may promptly initiate termination upon any of the following events:

1. The enrollee is no longer a qualified individual as determined based on information submitted by the enrollee or information obtained by the Exchange or whose eligibility changes such that they are eligible for a different QHP.

2. The enrollee dies.

3. Non-payment of premiums, after the exhaustion of any applicable grace period.

4. The QHP has been decertified, which constitutes a loss of Minimum Essential Coverage. The qualified enrollee will be given an opportunity to enroll in a new QHP pursuant to special enrollment periods set forth in § 1.6(D) of this Part.

5. The qualified individual selects a different QHP during an open or special enrollment period.

E. Voluntary Termination - The Exchange shall terminate enrollment at any time upon the request of an enrollee. Effective termination dates for voluntary termination shall be established by the Exchange.

F. Notice - The Exchange will provide an enrollee written notice of an involuntary termination that shall include the basis of the termination.

G. Effective Date of Termination.

1. Voluntary terminations - Upon submitting a valid voluntary termination request, coverage shall terminate on the last day of the month in which the request is made. The Exchange has discretion to grant an earlier termination date, on a case-by-case basis.

2. Involuntary terminations - If the enrollee is no longer a qualified individual as determined upon receipt of information from the enrollee or information obtained by the Exchange, coverage will terminate in accordance with 45 C.F.R. § 155.430, incorporated above at § 1.3 of this Part.

1.11 Minimum Essential Coverage Exemptions

A. In General - § 5000A of the Internal Revenue Code of 1986 (26 U.S.C. § 5000A), as added by the ACA, requires that for each month during the taxable year, a non-exempt individual must have minimum essential coverage, as defined under the law, or pay a shared responsibility payment.

1. The Exchange is authorized to issue exemptions to the minimum essential coverage requirement.

2. The Exchange may rely on HHS for this purpose.

3. The Exchange contact center and web site shall provide information to consumers regarding the exemption eligibility process.

B. Exchange Exemption Eligibility Determination - Any application for an exemption from the minimum essential coverage requirement submitted to the Exchange will be determined by the Exchange promptly and without undue delay.

1. To the extent applicable, the Exchange will use information already available to it, so as not to request duplicate information from the applicant.

2. An exemption applicant who has a Social Security number must provide such number.

3. An individual who is not seeking an exemption for himself or herself need not provide a Social Security number, except as required by 45 C.F.R. § 155.610(e)(3), incorporated above at § 1.3 of this Part.

4. Once the applicant's eligibility for an exemption is approved pursuant to exemption eligibility standards as defined in 45 C.F.R. § 155.605, incorporated above at § 1.3 of this Part, the Exchange will send the applicant a notice that will serve as the certificate of exemption. The notice will instruct the applicant to retain the certificate as proof of exemption. If the exemption is denied, the Exchange will send the applicant a notice containing instructions on how to appeal the denial.

5. If the Exchange determines the applicant eligible for an exemption, the Exchange will transmit to the Internal Revenue Service, the individual's name, Social Security number, exemption certificate number, and any other information required by the Internal Revenue Service.

6. The Exchange will attempt to verify information provided by the applicant in compliance with the requirements of 45 C.F.R. § 155.615, incorporated above at § 1.3 of this Part.

1.12 Agreements with Issuers

A. In General - The Exchange shall establish a certification process for all participating QHP Issuers.

B. Issuer Agreements - All QHP Issuers must enter an Issuer Agreement with the Exchange describing the issuer's obligations with regard to offering products and/or services on the Exchange.

1. Issuer Agreements shall be negotiated on an annual basis and formed in advance of the Annual Open Enrollment Period for the upcoming benefit year.

2. QHPs offered through the Exchange pursuant to an Issuer Agreement may vary from year to year.

C. Issuer Guidance - All QHP Issuers should adhere to the provided guidelines for plan certification, describing the desired components and features of plans offered on the Exchange.

1.13 SHOP Exchange

A. In General - § 1311(b)(1)(B) of the ACA and its implementing regulations, 45 C.F.R. Part 155 Subpart H, incorporated above at § 1.3 of this Part, provide for the establishment of a Small Business Health Options Program (SHOP) Exchange that is designed to assist qualified employers and to facilitate the enrollment of qualified employees into qualified health plans.

B. Terms and Conditions - To participate in the SHOP Exchange, a qualified employer or a qualified employee must register with the Exchange and accept the terms and conditions for participation. The SHOP Exchange may from time to time modify such terms and conditions for participation in the SHOP Exchange.

C. SHOP Enrollment - A qualified employer or a qualified employee shall submit a signed application for coverage prior to receiving coverage through the SHOP Exchange. All signatures required from a qualified employer or a qualified employee to complete an enrollment application may be obtained electronically. Any such electronic signature is valid and the legal equivalent of a signature obtained in another form.

D. Agents and Brokers - The SHOP Exchange shall establish a process by which a qualified employer or qualified employee may designate an insurance agent or broker to act on his or her behalf in interactions with the SHOP Exchange.

1. In order to enroll qualified employers and qualified employees through the SHOP Exchange, the agent or broker must be certified to participate in the SHOP Exchange and must have established an account with the SHOP Exchange.

2. A qualified employer or qualified employee may designate an agent or broker electronically.

E. SHOP Premium Aggregation - The SHOP Exchange shall provide each qualified employer with a bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due to the Qualified Health Plan issuers from the qualified employer. The SHOP Exchange shall also collect from each employer the total amount due and make payments to Qualified Health Plan issuers in the SHOP for all enrollees.

F. Due Date - The SHOP Exchange shall establish a monthly deadline by which premium payments must be received in order to make coverage effective on the first day of the following month.

G. Grace Period - Qualified employers shall have a thirty-day premium non-payment grace period. If full payment is not received by the end of the grace period, the SHOP Exchange may terminate coverage effective on the last day of the grace period.

1.14 Appeals

A. Designation of Exchange Appeals Entity - Any Exchange eligibility appeals other than Large Employer Appeals may be accepted, processed and adjudicated by EOHHS if, at such time as the appeal is filed, the Exchange has in effect a memorandum of agreement (MOA) designating EOHHS as the entity responsible for such appeals.

B. Procedures for Appeals Delegated to EOHHS by MOA - Specific requirements relating to the acceptance, processing, and adjudication of appeals by EOHHS shall be as set forth in 210-RICR-10-05-2.

1.15 Exchange Trust Payments

A. Establishment of Trust - The Exchange shall establish the Trust for the following purposes:

1. Collecting health and dental insurance premium payments from qualified employers and qualified individuals;

2. Remitting premium payments to QHP issuers on behalf of enrollees who participate in QHPs offered through the Exchange;

3. Performing functions ancillary to the collection and payment of premiums to qualified health plan issuers and the receipt of payments for such products and services as may be offered through the Exchange; and

4. Carrying out any other functions that are reasonably necessary in furtherance of the foregoing and in accordance with the establishment and maintenance of the Trust.

B. Payments to the Trust - Qualified individuals and qualified employers may remit premium payments to the Exchange to maintain participation in a QHP in accordance with all requirements under the Act and the Federal Regulations.

1. Premium payments may be made in advance of the coverage month to which the payment applies.

2. The monthly premium payment deadline shall be established by the Exchange.

3. Premium payments will be applied against open premium lines in chronological order, beginning with the oldest outstanding premium payment.

4. Payments may be received by the Trust from qualified individuals and employers for such products and services as may be offered through the Exchange.

C. Overdue Accounts - Individuals and Employers will be considered overdue when they have not paid a monthly bill in full by the designated due date.

1. Overdue accounts will be sent a late notice including the payment amount overdue, any applicable grace period, and the expected coverage termination date.

2. Late notices will be mailed or delivered electronically into the individual's or employer's account.

D. Payment Deposits - All premium payments described in § 1.15(B) of this Part will be deposited into one or more bank accounts, held in the name of the Trust, and

maintained at a bank branch located in the State of Rhode Island and insured by the Federal Deposit Insurance Corporation.

E. Payments from the Trust - Upon receipt and reconciliation of accounts among and between the Exchange and a QHP issuer, the Trust will remit premium payments to the QHP issuer in accordance with the issuer agreement and pursuant to procedures set forth by the Exchange. The Trust shall receive any such funds as may be permitted under state and federal law and regulation and remit to the Exchange.

F. Standards - All activities of the Trust must be performed in accordance with all applicable standards under the Federal Regulations and the Act including, without limitation, the oversight and financial integrity requirements of § 1313 of the Act.

G. Privacy and Security - All activities of the Trust shall conform with all applicable state and federal laws pertaining to the privacy and security of financial and confidential health information including, without limitation, those standards described in 45 C.F.R. §§ 155.260(a)-(g) and 155.270(a) and (b), incorporated above at § 1.3 of this Part, relating to conducting electronic transactions.

1.16 Request for the Promulgation of a Rule

A. The purpose of this section and § 1.17 of this Part is to prescribe the form of a Petition for Promulgation of Rules pursuant to R.I. Gen. Laws § 42-35-6 and the procedure for its submission, consideration, and disposition.

B. For purposes of this section and § 1.17 of this Part only, the following definitions shall apply:

1. "Department" means HealthSource RI

2. "Petition" means a request for the Promulgation of a Rule.

3. "Petitioner" means a person requesting the promulgation of a rule.

4. "Promulgate", with respect to a Rule, means the process of writing a new Rule, or amending or repealing an existing Rule.

5. "Rule" means the whole or a part of an agency statement of general applicability that implements, interprets, or prescribes law or policy or the organization, procedure, or practice requirements of an agency and has the force of law. The term includes the amendment or repeal of an existing rule. The term is used interchangeably with the term "regulation." The term

does not include the exceptions listed in R.I. Gen. Laws § 42-35-1(19)(i)-(vi).

C. A request to Promulgate a Rule must be in writing and include the following information:

1. The name and address of the Petitioner;

2. A plain statement identifying the Rule or proposed new Rule at issue;

3. A detailed statement of all facts relied upon by the Petitioner;

4. A plain statement requesting the Promulgation of a Rule, and further indicating whether Petitioner seeks a new Rule or the amendment or repeal of an existing Rule.

   a. In the case of a request for the repeal of an existing Rule, the Petitioner shall identify the Rule by title and/or RICR citation.

   b. In the case of a request for an amendment to an existing Rule, the Petitioner must identify with specificity any proposed additions, deletions, or other amendments. New proposed language must be clearly marked using underline formatting for proposed insertions, and strikethrough formatting for proposed deletions.

D. A request for the Promulgation of a Rule must be submitted to:

HealthSource RI

Attn: Legal Services

501 Wampanoag Trail

Suite 400

East Providence, RI 02915

1.17 Consideration and Disposition of Request for the Promulgation of a Rule

A. The Department shall promptly consider and respond to the request for the Promulgation of a Rule as provided in R.I. Gen. Laws § 42-35-6.

B. The Department may, at its discretion and within the thirty (30) day period prescribed by statute:

1. Hold a hearing for further consideration and discussion on the Petition; or

2. Request further information or documents from the Petitioner necessary for the full evaluation of his or her Petition.

C. A Petitioner may appeal the Department's final disposition of the request for the Promulgation of a Rule as provided in R.I. Gen. Laws § 42-35-15.

1.18 Petition for Declaratory Order

A. This section and § 1.19 of this Part state the requirements for submitting a request for a Declaratory Order under R.I. Gen. Laws § 42-35-8(b), and the procedure for its consideration and prompt disposition.

B. The following definitions shall apply to this section and § 1.19 of this Part only:

1. "Declaratory Order" means an order issued by the Department that:

a. Interprets or applies a statute administered by the Department;

b. Clarifies whether a rule, guidance document, or order issued by the Department applies to a Petitioner; or

c. Clarifies how a rule, guidance document, or order issued by the Department applies to a Petitioner.

2. "Department" means HealthSource RI

3. "Petition" means a request for a Declaratory Order.

4. "Petitioner" means a person requesting a Declaratory Order.

C. A request for Declaratory Order must be in writing and include the following information:

1. The name and address of the Petitioner;

2. A plain statement identifying the statute, rule, guidance document, or order at issue;

3. A detailed statement of all facts relied upon by the Petitioner;

4. A copy of any and all documents relied upon by Petitioner that are not otherwise accessible to the Department; and

5. A plain statement requesting a Declaratory Order, and further indicating whether Petitioner seeks:

    a. An interpretation or application of a statute administered by the Department;

    b. Clarification as to whether a rule, guidance document, or order issued by the Department applies to Petitioner; and/or

    c. Clarification as to how a rule, guidance document, or order issued by the Department applies to Petitioner.

D. A request for a Declaratory Order must be submitted to:

HealthSource RI

Attn: Legal Services

501 Wampanoag Trail

Suite 400

East Providence, RI 02915

1.19 Consideration and Disposition of Request for Declaratory Order

A. The Department shall promptly consider and respond to the request for Declaratory Order as provided in R.I. Gen. Laws § 42-35-8(c).

1. Should the Department schedule the matter for further consideration, the Department shall notify Petitioner in writing of the anticipated date on which the Department will grant or deny the request for Declaratory Order.

B. The agency may, at its discretion:

1. Hold a hearing for further consideration and discussion on the Petition; or

2. Request further information or documents from the Petitioner necessary for the full evaluation of his or her petition.

C. A Petitioner may appeal the Department's final disposition of the request for Declaratory Order as provided in R.I. Gen. Laws § 42-35-15.

1.20 Severability

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.

220-RICR-90-00-1

TITLE 220 - DEPARTMENT OF ADMINISTRATION

CHAPTER 90 - HEALTH BENEFITS EXCHANGE

SUBCHAPTER 00 - N/A

PART 1 - RULES AND REGULATIONS PERTAINING TO HEALTHSOURCE RI (220-RICR-90-00-1)

Type of Filing: Adoption

Agency Signature

E-SIGNED by Michael DiBiase — September 04, 2018

Agency Head Signature — Agency Signing Date

Department of State

09/24/2018

Regulation Effective Date

K.T. — September 04, 2018

Department of State Initials — Department of State Date