RHODE ISLAND GOVERNMENT REGISTER
PUBLIC NOTICE OF PROPOSED RULEMAKING

DEPARTMENT OF ADMINISTRATION

Title of Rule: Rules and Regulations Pertaining to the Rhode Island Reinsurance Program

Rule Identifier: 220-RICR-90-00-2

Rulemaking Action: Proposed Adoption

Important Dates:
Date of Public Notice: 07/23/2019
End of Public Comment: 08/23/2019

Authority for this Rulemaking:
R.I. Gen. Laws § 42-157.1-4

Summary of Rulemaking Action:
In accordance with the RI Administrative Procedures Act, the Director of HealthSource RI (Director) is proposing rule-making to adopt the Rules and Regulations Pertaining to the Rhode Island Reinsurance Program (Program). This rule is being adopted in accordance with R.I. Gen. Laws Chapter 42-157.1, which authorizes the Director to establish the Program and adopt rules, among other things. These rules and regulations will, in part, govern the information carriers 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.

Additional Information and Comments:
All interested parties are invited to request additional information or submit written or oral comments concerning the proposed adoption until August 23, 2019 by contacting the appropriate party at the address listed below:

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In accordance with R.I. Gen. Laws § 42-35-2.8, an oral hearing will be granted if requested by twenty-five (25) persons, by an agency or by an association having at

least twenty-five (25) members. A request for an oral hearing must be made within thirty (30) days of this notice.

Regulatory Analysis Summary and Supporting Documentation:

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 estimate 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)**
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

[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.

For full regulatory analysis or supporting documentation see agency contact person above.