GOVERNMENT OF PUERTO RICO
Office of the Commissioner of Insurance

March 15, 2022

RULING LETTER NO. CN-2022-313-AS

TO ALL DISABILITY INSURERS AND HEALTH INSURANCE ORGANIZATIONS WRITING HEALTH INSURANCE PLANS IN PUERTO RICO

FORM AND RATE FILINGS SUBMISSIONS TO BE EFFECTIVE FOR CALENDAR YEAR 2023

Dear Sirs and Madams:

In accordance with Chapters 8 and 10 of the Health Insurance Code of Puerto Rico ("HICPR"), Disability Insurers and Health Insurance Organizations (including, "HMOs") that write individual and small group health plans, including small groups health plans for bona fide associations, in Puerto Rico must submit to the Office of the Commissioner of Insurance ("OCI") each year, for review and approval, all the forms and rates in relation to metallic plans, all rates for metallic plans even if no change has been made, and rate increases equal to or greater than 10% of current rates. The requirements to file rates with the OCI, as set forth in Section 19.080(2)(a) of the Puerto Rico Insurance Code, 26 L.P.R.A., sec. 1908(2)(a), must be complied only by HMOs writing health coverage in the individual and small group market and all rate changes or modifications, including all rates for metallic plans, must be filed even if no change has been made.

To implement appropriate guidelines to promote an orderly form and rate filing submission for metallic plans to be effective on January 1, 2023, the OCI is hereby implementing the following standards:

IMPORTANT UPDATE NOTICE: NEW REGULATIONS AND HEALTH BENEFITS HAS BEEN IMPLEMENTED BY LAW: Read Carefully. This letter contains ten (10) attachments and important updates regarding Forms and Rates requirements for 2023 metallic plans. The use of outdated checklists and forms may result in a delay in the review and approval process of your filing.

I. Rates Submission

A. Timeline

Rate filings for non-grandfathered Individual plans that will be effective on January 1, 2023 must be submitted to the OCI on or before May 31, 2022. **The OCI will not guarantee the approval of the submitted rates for individual plans before October 1, 2022, if the carrier does not comply with the established submission deadline.** If the filing has to be returned to the carrier because the use of outdated checklists or non-compliance with the requirements of this letter, then the submission will be considered as not in compliance with the established submission deadline. As previously informed by the OCI, carriers must obtain approval of the metallic plans rates and forms before October 1st of each year. Carriers whose rates and forms have not been approved before October 1, 2022, will have to market, and make available for everyone, all of their metallic plans in the individual market, without a waiting period, throughout the open enrollment period (October 1 to December 31, 2022) and the entire year 2023, instead of just the open enrollment period.

Rate filings for non-grandfathered Small Group plans, including small group health plans for bona fide associations, must be submitted to the OCI on or before July 1, 2022. A carrier[1] wishing to have quarterly rate changes on small group plans, including small group health plans for bona fide associations, in 2022 must file rates for all quarters on or before July 1, 2022. **The OCI will not guarantee the approval of the submitted rates before November 1st for small group plans, if the carrier does not comply with the established submission deadline.**

Grandfathered individual and small group rate increase for HMOs and rate increases over 10% for Disability insurers must be filed at least ninety (90) days before they are to be used.

B. Rate Filing Submission Requirements

1. Every filing should be properly submitted through the SERFF system, **including all the information required in this ruling letter and its attachments**. See SERFF Rate Filing Submissions Instructions in Section I(F) of this ruling letter.

2. Rates for additional optional benefits by endorsements (if applicable) must also be submitted in the Rate Schedule tab in SERFF.

3. All Excel files should also be submitted also in PDF print out format.

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[1] Term use in this ruling letter to refer to a Disability insurer and an HMO.

4. All rate filings should be submitted in accordance with the requirements established in the Puerto Rico Rate Filing Instruction Manual (See Attachment 1).

5. The Federal Rate Review Justification Part I - Unified Rate Review Template (URRT) must be submitted in Excel and PDF under the corresponding Tab in SERFF (See Attachment 2). The PDF version must show all the submitted plans as shown in the Excel version.

6. The following documents must be included as part of the rate submission under the Supporting Documentation tab in SERFF (Please identify each document in SERFF with a name that match with the content of the document):

    a. Actuarial Memorandum shall comply with the requirements of Puerto Rico, and Part III Actuarial Memorandum and Certification Instructions (See Attachment 3). **The Actuarial Memorandum must be structured in the same format and order established in the mentioned Part III.**

    b. Puerto Rico Actuarial Certification (should be identified as "Certification of Data Accuracy";

    c. Actuarial Value Calculator Screenshots (for metallic plans only). Each plan must be identified with the name of the plan and its corresponding metallic level (i.e. Bronze, Silver, Gold, and Platinum). The screenshots must be submitted in Excel and PDF. Also, the PDF version of each AV Calculator must be fitted in only one page, as shown in the Excel version. The Actuarial Value Calculator to be used is the HHS 2014. If the filed rates apply to a POS plan, the actuarial value calculator must be properly completed;

    d. SERFF Rate template in Excel and PDF (**one metallic plan per page**). The template must include the effective date of the rates. Also, the Plan Id column of the template must include the name of the plan with its respective metallic level;

    e. Rate Manual. The manual must include the following:

        i. Quantitative development of the complete process to determine the final rate. This must include a detail explanation of the process from the base rate to the final rate of each of the submitted plans.
        ii. Each factor used in developing the rates,
        iii. Each adjustment factor used to determine the rates,
        iv. The federal standard age curve, and
        v. An illustrative example of the calculation of the family rate;

f. Puerto Rico Benefits Map in Excel and PDF. The Benefit Map must include for each proposed plan the benefit package to be offered by the carrier for the Small Group and Individual markets. (See Attachment 4);

g. Puerto Rico 2022 updated Rate Filing Checklist. The use of a checklist from previous years will result in a rejection of your filing. For each item that does not apply to the filed plan, the Actuarial Memorandum must explain the reasons for not applying. All separate documents required in this checklist must be identified as follows: (See updated 2022 Attachment 5)

   i. Comparative Table Rate Increase;
   ii. Calculation demonstration of Rate Increase;
   iii. Current and Proposed Age Distribution;
   iv. Quantitative development of Factors for rating;
   v. Comparative Table Cost Sharing Changes;
   vi. Quantitative development of New EHB;
   vii. Quantitative development of optional additional benefits;
   viii. Quantitative development of Prescription Drug coverage cost sharing design;
   ix. Quantitative demonstration of Paid to Allowed;
   x. Quantitative development of plan adjusted index rate;
   xi. Quantitative development of consumer adjusted premium rate.

h. Public form of the rate filing information to be placed on the OCI (OCS) website.

i. Certification of Unique Plan Design. If the plan has a unique plan design that does not work with the Federal Actuarial Value Calculator, a certification of Unique Plan Design shall be attached to the Supporting Documentation tab on SERFF. For details refer to Section VII of Attachment 1.

j. If applicable, present in excel and PDF separate evidence of the experience with any additional benefits to the basic coverage that is included in the policy without additional cost to the insured as an added value.

C. Use of Approved Rates and Prospective Revisions

1. The carriers **must only use** the rates filed and approved by the OCI.

2. Lower or higher rates cannot be used, even if the revised rate is on a group level and the rate is not higher than the approved one. Please note that audits will be made to verify that only approved rates are being used.

3. Carriers will not be allowed to implement rate changes to current rates before January 1, 2023, unless a carrier can justify the OCI that their financial solvency will be dangerously low without a rate change.

4. Once rates are approved, they cannot be changed during the year.

5. For the small group market, including small group health plans for bonafide associations, if the rates are increased on a quarterly basis they should be pre-filed all at the same time. No other quarterly rate increases will be accepted.

D. Rates to be made Public

The following documents will be published on the OCI website, after the approval of the rate submission:

a. The rates structures (SERFF Rate Template),
b. Preliminary Justification Part II: Written explanation of any rate increase that is 10% or over;

E. Grandfathered Rates Submission

1. Every filing must be properly submitted through the SERFF system, including all the information required in this ruling letter and its attachments, as applicable. See SERFF Rate Filing Submissions in Section I(F) of this ruling letter.

2. All Excel files must be submitted in both Excel format and PDF print out format.

3. All HMOs rate increases and all Disability insurers rate increases equal to or greater than 10% of rates one year prior must be submitted in accordance with the requirements established in the Puerto Rico Rate Filing Instruction Manual (See Attachment 1).

4. The documents previously mentioned in items I(B)(5) and (B)(6) of this ruling letter must be included as part of the rate submission.

F. SERFF Rates Filing Submissions

1. Every SERFF filing **must include the correct Type of Insurance (TOI), Sub-Type of Insurance (Sub-TOI), Market Type and Filing Type**. Incorrect TOI, Sub-TOI, Market Type, or Filing Type **will result in the filing's rejection without evaluation**.

2. SERFF filings must comply with Circular Letter No. CC-2015-1870-AV/AS of December 1, 2015 entitled "General SERFF Instructions for Form and Rate

Submissions". Please read carefully the mentioned circular letter before any submission.

3. SERFF filings shall be accompanied with a Transmittal Letter including the name of the carrier making the filing under the signature of an authorized person, in compliance with Section 3(a)(1) of Rule XXIV of the Regulations of the Insurance Code of Puerto Rico.

    i. The transmittal letter must be attached in the "Supporting Documentation Tab".

    ii. The carrier must identify in the transmittal letter all the metallic levels of the rates being submitted. For example: "we are submitting rates for two (2) Silver plans and one (1) Gold plan for a total of tree (3) metallic plans."

4. All the fields required in the "Rate/Rule Schedule Tab" must be completed. **A failure to complete them will result in the filing's rejection without evaluation.**

5. All supporting documentation must be included in the "Supporting Documentation Tab", including the Puerto Rico Actuarial Memorandum, Federal Actuarial Memorandum and Certification, Puerto Rico Actuarial Certification, Exhibits (if applicable), Actuarial Value Calculator Screenshots, Rate Manual, Puerto Rico Benefits Map, and the Puerto Rico Rate Filing Checklist.

6. The submitted rates to be approved must be included in the "Rate/Rule Schedule Tab".

7. Documents **must be saved in a non-protected PDF and Excel format**, as applicable, so that the file remains searchable and text can be copied from the document. **The submission of protected documents will prevent the filing's approval. It is the carrier's responsibility to verify before the filing's submission that all documents comply with this item.**

8. Every communication (e.g. any request for additional time to respond to an objection letter, any request of status) must be included in SERFF as a "Note to Reviewer". Every objection letter must be answered by means of a "Response Letter". The OCI will not accept responses to objection letters in a "Note to Reviewer". Other ways of communication will **not** be deemed as received.

II. Forms Submissions

A. Timeline

Forms filings for non-grandfathered individual plans that will be effective on January 1, 2023 must be submitted to the OCI on or before May 31, 2022. **The OCI will not guarantee the approval of the submitted forms before October 1, 2022, if the carrier does not comply with the established submission deadline**. As previously informed by the OCI, carriers must obtain approval of the metallic plans rates and forms before October 1st of each year. Carriers whose rates and forms have not been approved before October 1, 2022, will have to market, and make available for everyone, all their metallic plans in the individual market, without waiting period, throughout the open enrollment period (October 1st to December 31st, 2022) and the entire year 2023, instead of just the open enrollment period.

Form filings for non-grandfathered small group plans, including small group health plans for bona fide associations, must be submitted to the OCI on or before July 1, 2022.

B. Forms Filing Submission Requirements

1. As a reminder, we inform you that the annual submission of the metallic level plans is considered by our Office as a new product and therefore entails a comprehensive evaluation in its entirety. Therefore, any policy language in the forms that in the opinion of the analyst or the OCI or in accordance with the Insurance Code and the Health Insurance Code represents vague, unclear, or ambiguous language that may lead to error, confusion or misunderstanding will be pointed out to the insurers in a uniform way or in a specific way depending on the case that applies, regardless of whether said language has been approved in previous years. The approval of any policy language in a given year does not bind the OCI's evaluation of said language in subsequent years and does not bar a further review or revision or disapproval of the language in future filings or submissions.

2. Every filing must be properly submitted through the SERFF system and **include all the information required in this ruling letter and its attachments**. See SERFF Form Filing Submissions in Section II(E) of this ruling letter.

3. No endorsement to modify a previously approved metallic plan will be accepted.

4. Optional endorsements with additional benefits are accepted, as long as they are consistent with the coverage of the health plan and comply with the provisions of the Puerto Rico Insurance Code and Health Insurance Code. Rates must be filed concurrently with forms.

5. Attachments must be submitted in Adobe Acrobat (PDF) format unless another format is specifically required by a Reviewer or by this Ruling Letter. If a Reviewer requires that an attachment be submitted in another format (e.g., Excel), an additional copy of the attachment with the same name must also be submitted in PDF format. Scanned documents will not be accepted.

6. In compliance with Act No. 162 of December 30, 2020, which requires that the evidence of coverage and the medical plan identification card is provided in the Braille system for blind subscribers; the insurer shall submit a Certification of translation within the next sixty (60) days from the date of approval of this filing via new SERFF filing under the Supporting Documentation tab. The cover letter of the translation should make reference to the tracking number of the approved filing. You are advised that failure to comply with the aforementioned provisions of law will entail the imposition of sanctions.

7. The following documents must form part of the form submission:

    a. Essential Health Benefit and Preventive Services 2022 updated Checklist (See Attachment 6);

    b. Puerto Rico Form Filing 2022 updated Checklist (See Attachments 7A or 7B);

    c. Drug Formulary in accordance with the Essential Health Benefit Benchmark for Puerto Rico, if applicable. The formulary must be in final print format as it will be delivered to the insured.

        i. The formulary shall include a complete list of all covered drugs, including any tiering structure that it has been adopted and any restrictions on the manner in which the drug can be obtained and in a manner that is easily accessible to insureds, prospective insureds, OCI, and the general public.

        ii. The drugs in the formulary must be grouped into the same categories as the Essential Health Benefit Benchmark for Puerto Rico.

        iii. **The drug formulary filed with the forms must be the final formulary negotiated with the PBM and the one to be used by the carrier during the entire 2023.**

        iv. Once the formulary is marked with the Received and Filed stamp, it cannot be changed during the year, except for the changes allowed by Section 4.060(2) of the HICPR.

The carrier's website cannot require the individual to create or access an account or enter a policy number to view the formulary. If the carrier offers more than one plan, then the website must identify which formulary drug list applies to which plan.

d. Providers Directory (The Directory must be in final print format as it will be delivered to the insured.)

e. Table of Copayment, Coinsurance and Deductibles to be published in the OCI website (See Attachment 8 - 2022 updated). Please notice that this table does not replace the table of copayment, coinsurance and deductibles that must form part of the contract. The table of the contract must include the cost sharing for each covered service. This table must be submitted in a way that when printed the same it can be legible (size of the letter no less than 10 point).

f. Puerto Rico Contraceptives Methods Checklist (See Attachment 9). The Coverage of FDA-approved Contraceptive Products includes but is not limited to the list in Attachment 9.

g. Prescription Drug EHB-Benchmark Plan Benefits by Category and Class (See New Attachment 10)

6. All metallic plans and the copayment and coinsurance structure must be filed concurrently and cannot be changed during the year.

7. The metallic plans to be effective for calendar year 2023 must provide that any cost-sharing involved with the prescription drug benefit is included in the overall Maximum Out of Pocket (MOOP) total calculation. This Office has determined that the annual MOOP limit for calendar year 2023 is $6,350 for individual coverage and $12,700 for all other coverage.

8. During the open enrollment period, carriers must market all their metallic plans approved by the OCI; provided that carriers who voluntarily decide to offer their metallic plans outside the open enrollment period must market all said plans during the whole year 2023 and must not limit said marketing to special enrollment (qualifying events) instances. Additionally, the transmittal letter must disclose that the carrier voluntarily decided to offer or not during the whole year 2023 all the metallic plans approved by the OCI .

9. Essential health benefits discrimination is not allowed. One example, without excluding others, of such discrimination has been observed in the maternity benefit. Plans that offer maternity benefits and dependent coverage are required

to offer maternity coverage for dependents. The legal and regulatory standards for nondiscrimination in health-related insurance and other health-related coverage are applicable to individual, small group – including small group health plans for bona fide associations – and large group metallic plans, and to grandfathered and transitional health plans. *See* 45 CFR Part 92.

10. Each carrier is responsible for notifying providers about the ICD10 and dental health codes related to all the preventive services covered, in order to guarantee that such services are provided without cost sharing. Said codes must be published via the carrier's website for the attention of providers and consumers. **An updated evidence of compliance with this requirement must be presented as part of the submission in the Supporting Documentation Tab.**

C. Use of Approved Forms

1. Carriers **must only use** the forms filed and approved by the OCI, including the drug formulary, which forms part of the contract.

2. Once the forms are approved, they cannot be changed during the year.

D. Benefits that are legislated during the year.

If during the year 2022, after the issuance of this letter and before the completion of the health plans' review and approval process, the implementation of any new benefit is required by a state or federal law, ruling letter, circular letter, executive order, decree, or resolution; this Office will require that the language of the new benefit is incorporated in the policies pending approval. An insurer or health services organization is not exempted from complying with the legal or regulatory implementation of the new benefits just because this Office, for any reason, cannot carry out the aforementioned requirement.

E. Forms Information to be made Public

Each metallic plan description of benefits and metallic level, together with their corresponding table of copayment, coinsurance and deductibles, will be made public by the OCI. The Table of Copayment, Coinsurance, and Deductibles to be published in the OCI website must be submitted in both Excel and PDF format. (See 2022 updated Attachment 8).

F. SERFF Forms Filing Submissions

1. Every SERFF filing **must include the correct Type of Insurance (TOI), Sub-Type of Insurance (Sub-TOI), Market Type, and Filing Type**. An incorrect TOI, Sub-

TOI, Market Type, or Filing Type **will result in the filing's rejection without evaluation.** Please refer to the **NAIC Life, Accident & Health, Annuity and Credit Product Coding Matrix.**

2. SERFF filings must comply with Circular Letter No. CC-2015-1870-AV/AS of December 1, 2015 entitled "General SERFF Instructions for Form and Rate Submissions" and Circular Letter CC-2015-1869-AV/AS of December 1, 2015 entitled "General Guidelines and Requirements for Forms Submissions". **Please read carefully these circular letters before making any submission.**

3. SERFF filings shall be accompanied with a Transmittal Letter including the name of the carrier making the filing under the signature of an authorized person, in compliance with Section 3(a)(1) of Rule XXIV of the Regulations of the Insurance Code of Puerto Rico. The transmittal letter must be attached in the "Supporting Documentation Tab".

4. In addition to the transmittal letter, an explanatory memorandum shall be submitted, containing sufficient information to review the filing, including, without limitation, the following:

    a. Identify the metal level(s) of coverage:

        _# of Platinum # of Gold #of Silver # of Bronze

    b. Explain how each submitted form will be used. Any additional benefit to the basic coverage that is intended to be included in the policy as an added value at no additional cost, must include a detailed explanation of how the process will work from the subscription to the benefit to the payment of claims for said benefit. In addition, the benefit administration process must comply with all applicable provisions of the Puerto Rico Insurance Code and Health Insurance Code.

    c. A list of all changes made to the forms (including changes due to new legal requirements, as well as any other changes, such as the deletion of previously approved language or the addition of new language) setting forth the page numbers where the changes are found and the explanation for each changes.

    d. If the OCI approved an application (and enrollment form, if applicable) for use in a prior year, and the carrier intends to continue using the approved form without change in the upcoming plan year, include the form number and SERFF tracking number of the file containing the application. In this case, no resubmission of the form is needed.

e. If the OCI approved an endorsement form with optional and/or additional benefits for use in a prior year, and the carrier intends to continue using the approved form without change in the upcoming plan year, include the form number and SERFF tracking number of the file containing the application. In this case, no resubmission of the form is needed.

f. For small group plans, including small group health plans for bona fide associations, identify the conversion policy that the carrier will use to provide the individual conversion benefit.

   We have permitted unaffiliated companies to provide the individual conversion benefit where the group issuer does not offer any individual policies. From now on, however, the contractual arrangement between the two companies and sufficient details to verify its compliance with Section 17.070 of the Insurance Code of Puerto Rico must be submitted under the Supporting Documentation tab.

g. Identify the type of plan (HMO, PPO, POS, EPO, etc.)

h. For individual plans, disclose whether the carrier voluntarily decided to offer or not during the whole year 2023 all the metallic plans approved by the OCI.

5. All forms must be submitted in final format. No draft highlighted or redlined copy form should be included in the "Form Schedule Tab". **Every form included on the Form Schedule tab must be submitted in a clean final print, as intended for use. No insert pages will be accepted.**

6. All the fields required in the "Form Schedule Tab" and "General Information Tab" must be completed. A failure to complete them **will result in the filing's rejection without evaluation.**

7. Only forms that need to be approved by the OCI should be included in the "Form Schedule Tab". The OCI will not approve any forms that have not been included in the Form Schedule Tab (i.e. forms included in a "Note to Reviewer").

8. There must be only one attachment per schedule item on the Form Schedule. Multiple documents must not be included in one attachment.

9. Forms and documents **must be saved in a non-protected PDF format** so that the file remains searchable and text can be copied from the document. **The**

submission of protected documents will prevent the filing's approval. It is the carrier's responsibility to verify before the filing's submission that all forms and documents comply with this item.

10. Any supporting documentation must be attached to the "Supporting Documentation Tab", including evidence of previous approval, the table with copayments, coinsurance and deductibles to be published, certifications, memorandum of variable material, highlighted documents, and redlined copies, among others.

11. A memorandum of variable material is required if any forms contain bracketed variable text. The Statement of Variables (SOV) must contain an index to all brackets in the forms and fully explain the purpose for the variable text. It must also disclose the text that will be inserted into the brackets or explain under what circumstances the bracketed text will either be included or removed in its entirety. **Essential health benefits and cost sharing values must not be variable.**

12. A Summary of Benefits and Coverage (SBC) for each plan must be included in the Supporting Documentation tab. The carrier must use the most recent template available from the U.S. Department of Labor.

13. Once submitted, a form filing generally cannot be changed. **DO NOT** file amendments to a filing that is under review status, except where (a), (b), or (c) below, is true:

    a. Changes to the forms are required to be made in response to a form objection in the filing; or

    b. Changes to the forms are required to be made in response to a rate objection. In this case, send a Note to Reviewer in the form filing requesting an amendment to the filing in response to a rate objection. The Note to Reviewer must be sent in the filing you are requesting to change, and include specific details of the change requested, including the SERFF Tracking Number for the corresponding rate filing; or

    c. The filer has requested and been granted authorization to submit a change through an Amendment on the filing via Note to Filer in SERFF. To request a change to a form filing send a Note to Reviewer requesting to make a change to any SERFF field or to replace, modify, add, amend, or withdraw a form after it has been submitted for review.

i. The Note to Reviewer must be sent in the filing where the change will be made, and include specific details of the change requested, as well as the reason for the change.

ii. The reviewer analyst will notify in a Note to Filer whether the request is accepted or denied.

iii. If the request is accepted, the filing may be updated as directed in the Note to Filer.

iv. Do not make any modifications other than as specifically authorized in the Note to Filer. Otherwise, the reviewer analyst will require the removal of any unauthorized modifications.

d. Filings modified without proper authorization will be disapproved.

14. Every communication (e.g., a request for additional time to respond to an objection letter, a request of status) must be included in SERFF as a "Note to Reviewer". Every objection letter must be answered by means of a "Response Letter". The OCI will not accept responses to objection letters in a "Note to Reviewer". Other ways of communication will **not** be deemed as received.

15. Provide substantive responses to all objections and include the page numbers where the requested changes appear. If a requested change is not made, an explanation that includes sufficient legal justification for not making the change must be provided.

16. The documents mentioned in item II(B)(5) of this ruling letter must be included as part of the form submission in the "Supporting Documentation Tab" of SERFF.

G. Plan Renewal

1. The HICPR and the guaranteed renewability provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Affordable Care Act provide that if a carrier offers health plan in the group or individual market, it must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

2. A carrier that renews a plan in the group or individual market (including a renewal with modifications) must provide written notice of such renewal as follows:

a. For metallic plans in the individual market, the carrier must provide to each individual market policyholder a written notice of renewal before the first day of the next annual open enrollment period.

b. For transitional plans in the individual market, grandfathered and non-grandfathered coverage in the group market, the carrier must provide to each plan sponsor or individual, as applicable, a written notice of renewal at least (60) calendar days before the date of the renewal of the coverage.

3. The renewal notices must include the following essential content:

a. Information about changes, if any, to the enrollee's premiums;

b. Information about changes, if any, to the enrollee's coverage;

c. A statement disclosing that upon the termination of the enrollee's current plan, the enrollee is free to choose another health plan offered by the current carrier or by another carrier;

d. Information about other health plan options from the carrier;

e. Contact information from the carrier for the enrollee to call with questions; and

f. The notice must be written in a clearly understandable manner.

H. Plan discontinuation

1. Under the guaranteed renewability provisions of the HICPR, if a carrier decides to discontinue offering a particular health plan in the group or individual market, that plan may be discontinued by the carrier only if, among other things, the carrier provides in writing notice of such discontinuation to each plan sponsor or individual (and to all enrollees included under such coverage) at least (90) calendar days prior to the date of the discontinuation. The purpose of the discontinuance notice prior to the end of coverage is to inform enrollees that their current health plan is being terminated and that they have other health plan options.

2. Written notice must be provided as follows:

a. Individual metallic plans: the discontinuation notice must be sent on or before the first day of the open enrollment period. Since Puerto Rico's open

enrollment period runs from October 1st until December 31st every year, the notices must be sent on or before October 1st.

b. Transitional plans in the individual and group markets (including large group plans), small group metallic plans, including small group health plans for bona fide associations, and grandfathered plans: the discontinuation notices must be sent at least (60) days before the termination or renewal date of the health plan.

c. The discontinuation notices must include the following essential content:

   i. A statement that the health plan is being discontinued;

   ii. Suggestion of enrollment into a health plan of the carrier that is similar the discontinued plan, with information about the changes in the benefits and premiums arising out of the change from the old plan to the new plan; and a statement disclosing that upon the termination of the plan, the enrollee is free to choose another health plan offered by the current carrier or by another carrier;

   iii. Contact information from the carrier for the enrollee to call with questions

   iv. Information about other health plan options from the carrier;

   v. The notice must clearly explain the options for the employer or individual to obtain or renew health plan coverage; and

   vi. The notice must be written in a clearly understandable manner.

III. Large Group Rates and Form Filings

Large group rate filings, including large group health plans for bona fide associations, must not be submitted for the OCI's evaluation and approval. This rate filing exemption will apply to all health insurance organization or issuer underwriting health insurance coverage in the large group market, including healthcare service organizations (HMO).[2] However, rate increases of 10% or more over the previous year's rates for large group health insurance coverage, including large group health plans for bona fide associations, must be filed with the OCI for approval at least ninety (90) days before they are to go into effect, as their use requires the OCI's prior approval.

[2] The term "health insurance organization or insurer" includes also health services organizations (HMO), as defined in the Chapter 2 of the Puerto Rico's Health Insurance Code.

In addition, we must point out that all forms for the large group market, including large group health plans for bona fide associations, are subject to review and approval. Large group forms must comply with all the applicable provisions of the HICPR, which include among others, no Annual or Lifetime Limits, Coverage of Preventive Health Services, Extension of Dependent Coverage, and Preexisting Condition Exclusions.

IV. Supplemental Health Care Exhibit (SHCE)

All carriers are hereby required to complete and submit the Supplemental Health Care Exhibit to the NAIC and the OCI before March 30 of each year for Disability insurers, and before March 31 of each year for HMOs. **The carrier must include a copy of this exhibit as part of the rate filing requirements** in the "Supporting Documentation Tab".

Strict compliance with the provisions of this ruling letter is hereby required.

Cordially,

Alexander S. Adams Vega, Esq.
Commissioner of Insurance