



COMMONWEALTH OF PUERTO RICO  
**OFFICE OF THE COMMISSIONER OF INSURANCE**

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September 30, 2013

**RULING LETTER NO.: CN-2013-156-AS**

**TO ALL HEALTH INSURANCE ORGANIZATIONS AND INSURERS THAT WRITE HEALTH INSURANCE IN PUERTO RICO OTHER THAN MEDICARE ADVANTAGE OR SUPPLEMENTARY MEDICARE PLANS**

**AMENDMENT TO RULING LETTER NO. CN-2013-155-AS, DATED JULY 29, 2013, GUIDELINES FOR IMPLEMENTATION OF THE PROVISIONS OF THE PUERTO RICO HEALTH INSURANCE CODE**

Dear Sirs and Madams:

This Ruling Letter is issued to amend Ruling Letter CN-2013-155-AS, issued by the Office of the Commissioner of Insurance on July 29, 2013.

The Puerto Rico Health Insurance Code, Public Law No. 194-2011, as amended, vests the Office of the Commissioner of Insurance (hereinafter, OCI) with the power to issue ruling letters to provide guidelines for the implementation of the provisions of the Code. Exercising this power, we issue this Ruling Letter on the following topics:

- Actuarial Certification of compliance by the insurer with Section 10.050 and the remaining parts of Chapter 10, and applicable regulations and ruling letters
- Features used in establishing rates and applicable standards for rate changes arising from adjustments in benefit design and features
- Form and level of coverage of health insurance based on “metal” levels
- Medical Loss Ratio Report
- Content requirements for Certification of Creditable Coverage
- Procedure for enrollment outside of regular enrollment period
- Patient’s authorization for disclosure of medical records in the event of a claims audit

- Coordinated Care Plans
- Notice and Termination of Domestic Partnership Forms

**Actuarial Certification of compliance by the insurer with Section 10.050 and the remaining parts of Chapter 10, and applicable regulations and ruling letters. - (Section 10.030(G))**

All health insurance organizations and insurers shall obtain an actuarial certification as of March 31 every year, certifying that the insurer complies with the provisions of Chapter 10 and that the rating methods used are actuarially reasonable. Form CSS-AS-10-001, included as Appendix A, should be used for this purpose. The Insurer shall keep this certification available for inspection by the Commissioner of Insurance and it shall be accessible to any individual on the insurer's web page. In addition, this document shall include any other certification required in this Letter to be issued by an actuary.

**Features used in establishing rates and applicable standards for rate changes arising from adjustments in benefit design and features. (Section 10.050 (A) and (B) and Section 8.050)**

**I. Restrictions on Rates**

A. With regard to premium charged by health insurance organizations or insurers that offer health insurance in the individual or small group markets:

1. The rate for a given coverage may only vary according to the following criteria:

- a) If the coverage is individual or family coverage; according to the family composition alternatives indicated in Appendix B of this Letter;
- b) Age band according to the federal age curve table, included as Appendix C of this Letter and which in synthesis provides the following age bands:
  - i A single band for ages 0 to 20;
  - ii. One-year bands for persons from ages 21 to 63 and
  - iii. A single band for persons 64 years old and older.

- c) Tobacco use, except that the rate cannot vary in a ratio greater than 1.5:1 and may only apply to persons who may smoke or consume tobacco legally under state law;<sup>1</sup>
  - d) There may be no variation by geographical area since in Puerto Rico there is only one geographical area.
2. The rate for a given coverage may not vary based on criteria that are not specified in this paragraph.
- B. With regard to family coverage, the variations in the rates allowed under A(1)(b) and (c) will be applied to the portion of the premium that is attributable to each covered family member.
- 1. The total premiums for family coverage will be determined by adding the premium for each family member.
  - 2. With regard to family members under 21 years of age, only the rates for the three (3) oldest covered children will be taken into account in calculating total family premium.
- C. The above paragraphs A and B are not applicable to the coverage of exempt grandfathered health insurance plans.

## II. EHB Benchmark Plan

- A. Under Section 2.050, in order to consider that individual or small group health insurance provides essential health benefits, the plan must provide the "Minimum Set of Essential Health Benefits." This means that the health insurance plan as a minimum covers the following:
- 1. Standard coverage provided in the Optimo Plus PPO product approved by the United States Department of Health and Human Services (HHS),<sup>2</sup> as the essential health benefits plan or

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<sup>1</sup> "Tobacco use" means the use of tobacco an average of four (4) or more times a week within a period of no more than six (6) months. This includes the use of tobacco products, except for the use of tobacco for religious or ceremonial purposes. In addition, tobacco use will be defined as the last time the tobacco product was used.

<sup>2</sup> On February 20, 2013, HHS approved the rule "Standards Related to Essential Health Benefits, Actuarial Value and Accreditation" in which the EHB Benchmark Plan selected by Puerto Rico is shown as the Optimus Plus PPO. You may find a copy of the PR EHB Benchmark Plan and of the Puerto Rico State Requirements on the OCI web page.

"EHB Benchmark Plan", and for pediatric vision services shall provide the coverage of the "Federal Employees Dental and Vision Insurance Program."

2. The limitations on cost-sharing requirements for preventive care as described in Section IV, to be found on page 5 of this Letter.
  3. Provided on some "metal" levels of coverage described in Section 2.050(D) of the Puerto Rico Insurance Code.
- B. Health insurance will not exclude the insured from coverage in any category of essential health benefits.
- C. Health insurance, including grandfathered plans, which include any coverage offering essential health benefits (EHB) may not impose lifetime caps on such benefits.
- D. Health insurance organizations or insurers that offer health insurance in the individual market with essential health benefits may not include or require the following services as essential health benefits:
1. routine non-pediatric dental services;
  2. routine non-pediatric vision testing or
  3. long-term care in nursing homes.
- E. When health insurers are reasonably certain that the person has obtained pediatric dental coverage under another policy of a dental plan authorized by the Commissioner, it shall not be deemed that the health insurance organization or insurer has failed to provide essential health benefits if they offer individual health insurance, which combined with an authorized dental plan ensures full coverage of the essential health benefits. If pediatric dental coverage is not included, an endorsement to that effect must be issued.

### **III. Prohibition of discrimination in offering essential health benefits**

- A. It will be deemed that a health insurance organization or insurer is not providing essential health benefits if the benefits design or the implementation of such discriminates by reason of age, life expectancy, current or foreseeable disability, degree of medical dependency, quality of life or other health conditions of the person.
- B. Health insurance organizations or insurers may not discriminate on

the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

- C. It will not be interpreted that these provisions impair the capacity of the health insurance organization or insurer to implement administrative procedures for health care services.
- D. No health insurance organization or insurer may discriminate for health-related factors.
- E. No health insurance plan except grandfathered plans may prohibit a subscriber from participating in an approved clinical trial for cancer or terminal illness or terminal condition. The health insurance plan may not deny or limit coverage for routine expenses for services that are provided in connection with a clinical trial. In addition, health insurance plans may not discriminate against participants of a clinical study or trial.

#### **IV. Cost-sharing requirements**

- A. All health insurance organization or insurers that write health insurance in Puerto Rico will provide coverage for the following preventive care services, regardless of cost-sharing, additional cost, co-insurance or deductible requirements:
  - 1. Preventive care services with an "A" or "B" classification in the most recent recommendations of the United States Preventive Services Task Force.<sup>3</sup>
  - 2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
  - 3. With regard to infants, children, and adolescents up to twenty-one (21) years old, preventive care services and screening, according to age, recommended by the Health Resources and Services Administration.
  - 4. With regard to women, preventive care and screening services recommended by the Health Resources and Services Administration.

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<sup>3</sup> For a complete and updated list of the recommended preventive care services go to: <http://www.healthcare.gov/center/regulations/prevention/recommendations.html>.

- B. Recommended preventive care services shall be provided without any cost-sharing, additional cost, co-pay, co-insurance or deductible requirements, when the services are offered by providers in the network contracted by the health insurance organization or insurer. If the health insurance organization or insurer does not have a provider that offers the preventive care service or a provider network that offers reasonable access for the insured to such services, the health insurance organization or insurer will cover the services, even when they are offered by a provider that is not in the contracted network, without imposing any cost-sharing requirements or other related costs.
- C. In recognition of the fact that preventive care services may be provided as part of an office visit where other health care services are provided, the following rules have been established with regard to cost-sharing requirements:
1. If the preventive care service is billed separately from the office visit, cost-sharing may be imposed with regard to the office visit (this will not be applicable to the preventive care services).
  2. If the preventive care service is not billed separately from the office visit and the primary purpose of the visit is to receive preventive care services, cost-sharing may not be imposed with regard to the office visit or for the preventive care services.
  3. If the preventive care service is not billed separately from the office visit and the primary purpose of the visit is not to receive preventive care services, cost-sharing may be imposed with regard to the office visit.
- D. The preventive care services requirements mentioned in paragraphs A, B, and C are applicable to individual market contracts and group market contracts that are not grandfathered plans.
- E. The Commissioner will make any changes, if any, in the limitation on cost-sharing requirements applicable to health insurance that begins after 2014.
- F. In the case of preferred network plans, cost-sharing paid by or on behalf of an insured for services provided outside of the network will count towards the annual cost-sharing limit, as defined in above paragraph E.

G. Emergency coverage will be provided as follows:

1. When the provider is outside of the network, no requirement of any kind may be imposed for the prior authorization of emergency services, nor may any limitation be imposed on coverage that is more restrictive than the limitations that are applicable to emergency services received from a provider in the network.
2. If services are provided outside of the network, cost-sharing will be limited as provided in Section 24.110 of the Chapter on Use Review and Determination of Benefits of the Puerto Rico Health Insurance Code.

**Form and level of coverage of health insurance based on “metal” levels.**

- I. Calculation of the actuarial value to determine level of coverage<sup>4</sup>
  - A. Health insurance organizations or insurers will use the Actuarial Value (AV) Calculator developed and provide by the HHS to calculate the AV of a health insurance policy. An actuarial certification prepared by an actuary who is a member of the American Academy of Actuaries, certifying that this mechanism was used to calculate the Actuarial Value of the health insurance policy shall be submitted.
  - B. The AV that is calculated according to paragraph A and within a minimum variation as defined in paragraph D below, will determine whether the health insurance plan is classified at a bronze, silver, gold or platinum metal level.
  - C. The metal levels of coverage under Section 2.050 are:
    1. The bronze plan is health insurance that has an AV of 60%
    2. The silver plan is health insurance that has an AV of 70%
    3. The gold plan is health insurance that has an AV of 80%.
    4. The platinum plan is health insurance that has an AV of 90%.
  - D. The variation allowed in the AV of the health insurance plan that does not produce a difference in the actual dollar value of the health insurance is +/-2 percentage points.

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<sup>4</sup> Actuarial Value " or "AV" means the average percentage paid by a health insurance plan of the total cost of allowed benefits.

## II. Summary of Benefits and Coverage (SBCs); Uniform Glossary:

- A. Health insurance organizations and insurers that offer health insurance in the individual market will provide free of charge a written summary of benefits and coverage (SBC)<sup>5</sup> of the health insurance plan to the subscriber or insured on the date of the renewal period. In the case of applicants for health insurance, the SBC will be furnished as soon as possible after the receipt of a request for the SBC or the application for health insurance, which shall be no later than seven (7) business days after the receipt of the application, except if there has been any change in the information before the first day of coverage, in which case an updated SBC will be provided no later than the first day of coverage.
- B. The SBC will be provided as follows:
  1. In the event of renewal of the health insurance:
    - a) If the insurer requires that the health insurance renewal application be submitted in writing (on paper or electronically), the SBC will be provided no later than the date on which the application package is distributed.
    - b) If the plan renewal is automatic, the insurer will provide the SBC at least 30 days before the renewal period.
  2. It will be deemed that the insurer has complied with the requirement to provide an SBC to the insured and the insured's dependents if an SBC is mailed to the last known address of the principal insured. However, if the address for a dependent is different from the address of the principal insured, the insurer will also mail an SBC to the last known address of the dependent.

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<sup>5</sup> The Summary of Benefits and Coverage (SBC)

3. The SBC will be hand delivered, mailed or if there is written authorization from the applicant or insured, delivered by email or by access to the web page when the form being used may be recorded and printed. No charge may be made for SBCs printed on paper.

C. SBC content requirements:

1. Uniform definitions of insurance and medical terminology so that consumers may compare health insurance plans and understand the terms or exceptions of the coverage;
2. A description of the coverage that includes cost-sharing for each category of service benefits, deductible, co-insurance and co-pay obligations;
3. Exceptions, reductions, and limitations of coverage;
4. Provisions on renewal and continuation of coverage;
5. A statement to the effect that the coverage provides essential health benefits according to the Health Insurance Code and the respective ruling letters, and the color of the “metal” level;
6. A signed statement that the SBC is only a summary and that the policy, certificate or contract of the health insurance should be consulted to learn about the contractual provisions regarding the coverage;
7. The contact information for the customer service area to answer questions and obtain a paper or electronic copy of:
  - a. the health insurance policy, certificate or contract;
  - b. the list of network providers;
  - c. the list of covered drugs;
  - d. the uniform definitions as required in C(1), above.
8. Summary of the benefits and coverage provided outside of Puerto Rico, if any, or an Internet address (or similar contact information) where this information could be obtained;

9. The SBC will be provided in a uniform format in Spanish, using terminology that can be understood by an average person. The SBC will be provided as a separate document that will be no longer than 4 pages, printed on both sides in a 12-point or larger font.

### **III. Standards and procedures for the submitting individual, small group, and SMB health insurance plans to the Commissioner of Insurance for approval.**

- A. Filing of Rates and Forms for Individual, Small Group and, SMB plans and changes in rates.

Under the provisions on requirements for filing rates and forms set forth in Section 1003 of the federal Patient Protection and Affordable Care Act (PPACA), and Sections 8.070(B), 10.050(A), (B), (H), (M), and 10.090 of the Health Insurance Code, health insurance organizations and insurers must submit all rates and forms for consideration by the OCI for marketing to individuals, small groups, and SMB employers plans that are not grandfathered plans. Rates and forms shall be filed using the System for Electronic Rate and Form known as SERFF; rates and forms filed otherwise will be returned without being evaluated.

We must clarify that any provision of Sections 11.110, 12.020(2), and 19.080 of the Puerto Rico Insurance Code that is not incompatible with the new Health Insurance Code or with this Ruling Letter will continue to be in effect. In the case of individual health insurance, the health insurance organization or insurer may use the health plan that was submitted for consideration by the OCI 90 days after the filing, unless the Commissioner denies approval.

The guidelines in Ruling Letter 2011-128-AV and the procedures provided in Circular Letter No. 2012-1822-AV will govern the filing for consideration and approval by the Commissioner of any rate or revision or modification of such with regard to health insurance plans.

- B. Modification of Forms of Policies or Evidence of Coverage to Include Essential Health Benefits.

Policy forms or evidence of coverage approved by this Office must be duly modified to include essential health benefits as defined in the Code and in this Ruling Letter. Health insurance organizations

and insurers must file adequate evidence of compliance with this requirement with this Office on or before October 1, 2013. The required codifications shall include all of the essential and mandatory health benefits required in the applicable state and federal legislation regarding policies or evidence of coverage for health insurance in Puerto Rico.

When the policies or evidence of coverage approved by this Office provide essential health benefits and include the mandatory benefits required in the applicable state and federal legislation, certification to such effect shall be submitted within the term specified above. The certification must refer to the identification number of the form and the respective date of approval.

You are advised that, except for plans protected as grandfathered plans, any form that is not modified to include the EHB and mandatory benefits or for which certification to that effect is not provided will be deemed to be automatically withdrawn.

### **Medical Loss Ratio Report**

Section 2.050(K) of the Puerto Rico Health Insurance Code establishes the obligation of health insurance organizations and insurers to directly use 80% of the premiums for individual and SMB employer health insurance policies and 85% of the premiums for large group health insurance policies, and to reimburse the insureds for the difference between that amount and the amount actually spent, if it was less. Likewise, Section 2718 of the Public Health Service Act, as amended by the federal Patient Protection and Affordable Care Act (ACA), established the obligation of all health insurance organizations and insurers that write health insurance to reimburse the insureds or subscribers, when the medical loss ratio obtained in the previous year is less than 80%.

In order to monitor compliance with this requirement, ACA requires that these entities submit a medical loss ratio report to the US Secretary of Health. This report must be filed on or before June 1 every year, and will include for the calendar year prior to the date of filing of the report.

According to the duty imposed on the Commissioner in Section 2.030(2) of the Puerto Rico Insurance Code of enforcing compliance by our licensees with state and federal guidelines and in conformance with the authority vested under Section 2.030(12) of the Code

to obtain information, all health insurance organizations and insurers that write health insurance in Puerto Rico are required to file a copy of the Medical Loss Ratio Report with the Office of the Commissioner of Insurance on or before August 10, 2013, and for subsequent years, on the same date on which they must file with the US Secretary of Health. Likewise, these entities must report on a separate document the total amount, if any, that must be reimbursed, the market segment to which the reimbursements will be applied, the date on which reimbursements will be paid, and the method to be used for this disbursement.

**Requirements for the Certification of Creditable Coverage (Section 10.100 and Section 8.080)**

- A. This Section is applicable health insurance organizations or insurers that offer health insurance in the individual, small and medium-size group, and SMB employer markets.
- B. Certification will be provided free of charge to covered persons under health insurance or persons who have had coverage in the past as follows:
  1. Automatic certification will be provided at the time the person ceases to be covered by the health insurance plan, and
  2. Within 24 hours of being requested by the person. Request for certifications may be made by the person or on behalf of the person twenty-four (24) months of the termination of coverage.
  3. The insurer shall provide the certification in writing to the insured or if requested by the insured, the certification may be delivered to another health insurance organization or insurer that accepts receiving the information
  4. The certification shall include the following:
    - a. The date of issue of the certification;
    - b. The name of the person or dependent for whom coverage is being certified;
    - c. Other necessary identification information such as the insured's identification number in the policy; and the

name of the principal insured, if the certification is for a dependent or includes a dependent;

- d. The name, address, and telephone number of the health insurance organization or insurer that issues the certification, available for obtaining more information on the certification;
  - e. A statement:
    - i. that the person had at least eighteen (18) months of creditable coverage, not counting the days of creditable coverage before any substantial interruption of the coverage, or
    - ii. the date on which the person first applied for coverage, the date on which creditable coverage began and the date on which the creditable coverage ended, unless the certification indicates that the creditable coverage is still in effect on the date of the certification.
  - f. The statement will refer to the most recent period of continuous coverage ending on the date of termination of coverage. If the person requests a certification under above paragraph 2, and it is so specified, a certification is provided for each period of uninterrupted coverage within the 24-month period ending on the date of the request or that continues as of the date of the request. A separate certification will be provided for each period of uninterrupted coverage.
  - g. The health insurance organization or insurer may include the person and the person's dependents in a single certification. This may be done if the certification provides all of the necessary information for each person, and the information that is not identical is stated separately.
5. Health insurance organizations or insurers shall establish a procedure for individuals and their dependents to request and receive certification of creditable coverage.

- C. If the accuracy of the certification is being questioned or certification is not available when the person needs it, the person has the right to demonstrate creditable coverage (and the waiting and enrollment periods) by other means.
1. The health insurance organizations or insurers will take into account the insured's statement and all of the information submitted on behalf of the person in making the determination with regard to whether or not the person has eighteen (18) months of creditable coverage.
  2. The health insurance organization or insurer refuses to credit the coverage if the person refuses to authorize the organization or insurer to request or receive the certification of creditable coverage.
  3. Failure by the person to obtain certification may not be considered as evidence of the absence of creditable coverage.
  4. Evidence that may be used to establish creditable coverage and the waiting or enrollment periods, in the absence of certification, includes the following documents: explanations of benefits (EOB); claims or other correspondence related to the health insurance, explaining coverage; payroll check stubs showing withholding for health insurance coverage; an identification card from the health insurer; a certification of group health insurance coverage; records of the health care providers indicating the coverage; statements by third parties confirming the periods of coverage; and any other relevant documentation that shows the periods of coverage of the health insurance. Telephone calls by the insurer to a third party to verify creditable coverage may also be used as evidence.

**Procedure for enrollment outside of regular enrollment period (Section 10.150)**

- A. Health insurance organizations and insurers in Puerto Rico have the obligation to provide coverage to all individuals who request coverage without requiring risk assessment or a waiting period due to preexisting conditions. The individual will have the right to enroll in the health insurance plans that the health insurance organization or insurer may have available in the individual health insurance market.

- B. Guaranteed enrollment in health insurance plan is provided in fixed enrollment periods: an initial enrollment period and subsequent annual enrollment periods. The initial enrollment period will run from October 1, 2013 until March 31, 2014, and it is further provided that if an application for insurance is received on or before December 31, 2013, the application will be processed and the health insurance coverage will be effective on January 1, 2014. Subsequently, the annual enrollment periods will be between October 1 and December 31 of every year. In any case, if the application is received between the 1st and 15th day of the month, the coverage will be effective on the 1st day of the following month. If the application is received between the 16th and 31st day of the month, the coverage will be effective on the first day of the second month after the receipt of the application.
- C. Any individual plan that has been written during the initial enrollment period or during any fixed annual enrollment period described in the previous paragraph, shall be renewed during the subsequent fixed annual periods, that is to say between October 1 to December 31 of each year. If renewal is not done during this period, the plan will be deemed to be renewed retroactively as of the 1st of January, if the insured renews the plan on or before January 31.
- D. If the applicant for health insurance does not enroll within the fixed enrollment period being provided herein, the applicant will not have a right to guaranteed enrollment in the individual health insurance until the next annual enrollment period. As an exception to the above, a health insurance organization or insurer will be obligated to extend coverage during special enrollment periods <sup>6</sup> or at any time if no special enrollment period is provided by law, under the following circumstances: 1) the situations set forth in paragraphs C and D of Section 10.150 of the Puerto Rico Health Insurance Code, 2) if a qualifying event occurs as defined in Section 603 of ERISA, or 3) in any of the circumstances described below:

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<sup>6</sup> "Special enrollment period" means the period during which a person or a covered person may enroll or change enrollment in a health insurance plan, other than the initial or annual enrollment periods, when certain events occur that qualify the person for the enrollment.

1. The eligible person or the person's dependent lose the minimum coverage with essential health benefits;
  2. The eligible person acquires a dependent through marriage, birth, adoption or placement for adoption;
  3. The eligible person enrolled in or failed to enroll in a health insurance plan unintentionally, inadvertently or erroneously due to error, misrepresentation or lack of action of any official, employer or agent of the health insurers or HHS or its instrumentalities, as evaluated and determined by the health insurance organization or insurer. In such cases, the health insurance organization or insurer may take the necessary action to correct or eliminate the effects of such error, misrepresentation or lack of action;
  4. The covered person proves to the health insurance organization or insurer that the health insurance plan in which the person is enrolled materially violated the terms of the contract with that person;
  5. The person is eligible for the first time or once again becomes eligible. In these cases, where existing coverage under an eligible employer group plan that is no longer financially viable or does not even provided a minimum value for the next year of the employer health insurance plan, the health insurance organization or insurer will allow the eligible persons to have access to the coverage during a special enrollment period before coverage under such employer plan ends; and
  6. An eligible person or a covered person applies for new health insurance due to a change of residence.
- E. The same rules for effectiveness of the coverage will be applicable as provided in above paragraph B and in Section 10.150 (B), except in the cases of birth or adoption, in which case the provisions of Section 54.060 will prevail. In the event of marriage or that the person loses coverage of the minimum essential benefits, the plan must be effective on the first day of the following month.
- F. Guaranteed enrollment is an additional guarantee for the insured and nothing in the above provisions will be deemed to be a prohibition or limitation on the capacity of an insurer to write individual health

insurance at any time other than during such period. It is further provided that in 2014, individual health insurance plans that are acquired on or after January 1, 2014, will have a period of coverage of less than one year to comply with federal regulations that require that all plans should be renewed on January 1, 2015. Subsequently, all plans must be renewed on the first day of January of every year.

It shall not be deemed that the periods provided herein require cancellation of health insurance plans or modification of renewal periods for individual health insurance that went into effect 2013. These plans may end their policy year during 2014. According to federal regulations, when the health insurance plans ends in 2014, the insured will have a special guaranteed enrollment of 60 days in which to enroll in the health insurance plan of his or her choosing that complies with the new legal requirements.

**Patient's authorization for disclosure of medical records in the event of a claims audit (Section 6.090(C))**

Chapter 6 of the PR Health Insurance Code, titled Audit of Claims Submitted to Health Insurance Organizations or Insurers is directed at standardization of the provision on auditing claims for health care services submitted to health insurance organizations or insurers and third-party administrators. These audits are performed to determine whether the information in the medical records of the provider matches the services shown on the claim for payment submitted by an insured or a provider. Furthermore, Chapter 6 establishes provisions directed at mitigating conflicts that may arise as a result of the use of such medical records.

To this effect, Section 6.090 titled Confidentiality and Authorization, provides that the participants in a claims audit shall comply with all federal and state legislation and all contractual agreements related to the confidentiality of patient information. This Section also requires that particular authorization be obtained for claims audits, in cases where the statement of condition requested by the provider on admitting the patient does not show authorization by the patient of disclosure of the patient's medical records.

Health insurance organizations and insurers will comply with this requirement for patient consent and include a statement in the application for health insurance to the effect that the applicant consents to have the insurer carry out claims audits for health care services. Otherwise, health insurance organizations or insurers should obtain this authorization from the patient for disclosure of medical records for claims audits, using Form CSS-I-06-001, included as Appendix D of this Letter.

**Coordinated Care Plans**

For health insurance plans that provide for the designation of a primary care provider, it should be indicated to the insured or subscriber that he or she has the right to select the provider of his or her preference from among those that are available in the network, including pediatricians. If the insured does not exercise this right within a period of 30 days, the health insurance organization or insurer may designate a primary care provider until the insured makes a selection.

**Forms for Including and Terminating a Domestic Partnership**

Pursuant to Chapter 10 of the Puerto Rico Insurance Code, domestic partnership couples are eligible to obtain an individual health insurance plan. Insurers and health insurance organizations that write individual health insurance plans should use Form CSS-AS-10-002 which is included as Appendix E of this letter to notify the existence of a domestic partnership and include the dependents of the partner in an individual health insurance plan. In addition, health insurance organizations or insurers should use Form CSS-AS-10-003 included as Appendix F to notify the termination of the domestic partnership.

**Circular and Ruling Letters substituted by this Ruling Letter**

The guidelines set forth in the following letters are made a part of this Ruling Letter:

1. Ruling Letter No. 2011-132-AV
2. Circular Letter No. 2013-1825-D
3. Circular Letter No. 2011-1817-AV
4. Ruling Letter No. 2013-155-AS

**Caveat**

You are advised that failure to comply with any of the guidelines set forth herein will make you subject to sanctions as provided in the Puerto Rico Health Insurance Code.

Strict compliance with the provisions of this Ruling Letter is hereby ordered.

Very truly yours,

SIGNED

Angela Weyne-Roig  
Commissioner of Insurance

**ACTUARIAL CERTIFICATION  
COMPLIANCE OF RATES WITH CHAPTER 10 PROVISIONS**

I, \_\_\_\_\_ based on an examination of the appropriate records, certify that the premium rates for individual health insurance provided by the health services organization or insurer \_\_\_\_\_ were established using actuarially reasonable assumptions and rating methods, and in addition, comply with the requirements established in Section 10.050, the remaining parts of Chapter 10 of the Puerto Rico Health Insurance Code, on Individual Health Insurance and Guaranteed Enrollment, the regulations and interpretive ruling letters, and applicable federal laws and regulations.

IN WITNESS WHEREOF: I set my hand to this Annual Compliance Certification in \_\_\_\_\_ Puerto Rico, this \_\_ day, 2 \_\_\_\_ .

\_\_\_\_\_  
Signature

\_\_\_\_\_  
\_\_\_\_\_  
Address and Telephone Number

\_\_\_\_\_  
Email

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
ADDRESS AND TELEPHONE NUMBER OF THE HEALTH INSURANCE ORGANIZATION

**Family Composition Categories**

1. Individual Subscriber
2. Subscriber plus Spouse - 2 adults
3. Subscriber plus Child -1 adult and 1 child
4. Family member
5. Child only
6. Children only
7. Optional or Collateral Dependent

## Age Factors

## Federal Age Curve

Age	Factor	Age	Factor	Age	Factor
0-20	0.635	35	1.222	50	1.786
21	1	36	1.23	51	1.865
22	1	37	1.238	52	1.952
23	1	38	1.246	53	2.04
24	1	39	1.262	54	2.135
25	1.004	40	1.278	55	2.23
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.5	61	2.81
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 or older	3

Appendix D

**PATIENT'S AUTHORIZATION FOR DISCLOSURE OF  
MEDICAL RECORDS IN THE EVENT OF AN  
AUDIT OF A HEALTH CARE SERVICES CLAIM**

I \_\_\_\_\_, patient number \_\_\_\_\_, of legal age, and a resident of \_\_\_\_\_, Puerto Rico, in the absence of an authorization to disclose my medical records, hereby authorize the provider, or the person or entity designated \_\_\_\_\_, hereinafter, the "provider" to share and/ or disclose such information in my medical records that may be necessary to perform a claims audit on the health care services I received.

This authorization is extensive to the audits performed by an entity or authorized representative thereof under the provisions of Chapter 6 of the Puerto Rico Health Insurance Code and applicable federal and state legislation.

In witness whereof I set my hand to this document in \_\_\_\_\_, Puerto Rico this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Name in print

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relation to the patient or  
capacity of appearance

If your are representing the person whose information is being requested, whether the person is a minor or a disabled person, you must provide documentation proving your legal authority (For example: an authorization form, a duly constituted power of attorney, guardianship documents, court order, etc.)

**NOTIFICATION OF DOMESTIC PARTNERSHIP  
AND INCLUSION OF DEPENDENTS OF THE DOMESTIC PARTNER  
INDIVIDUAL HEALTH INSURANCE**

**Read these instructions carefully:**

This sworn statement contains the necessary criteria for applying for coverage for yourself and your domestic partner. You do **NOT have to swear to this statement in the presence of an attorney-notary**. Your signature and that of your domestic partner are sufficient to establish under oath that **everything that is set forth here is true**.

In the event that this document contains any inaccurate or untrue information, you and your partner are barred from signing this document.

Any person who knowingly and with the intention to defraud submits false information in an insurance application or who submits, assists in submitting or causes to be submitted a fraudulent claim for the payment of a loss or other benefit, will commit a felony, and if convicted, will be subject to a penalty for each violation of a fine of not less than five thousand dollars (\$5,000), nor greater than ten thousand dollars (\$10,000) or imprisonment for a fixed term of three (3) years, or both penalties. If there are aggravating circumstances, the established fixed penalty may be increased up to a maximum of five (5) years; and in the event of mitigating circumstances, may be reduced to a minimum of two (2) years.

**SWORN STATEMENT**

We, \_\_\_\_\_ (name, initial and paternal and maternal surnames of the principal insured), of legal age, single, a resident of \_\_\_\_\_, Puerto Rico and \_\_\_\_\_ (name, initial and paternal and maternal surnames of the domestic partner) of legal age, single, a resident of \_\_\_\_\_, Puerto Rico, state under oath that we have been living together as a couple since \_\_\_\_\_, \_\_\_\_\_ (year) and comply with the criteria set forth below for eligibility to the requested health insurance or the health insurance of the principal insured.

**Criteria for Domestic Partnerships**

We swear under penalty of perjury or any other applicable penalty, that we meet the following criteria:

- We are both 21 years old or older;
- We are not married;
- We have the full legal capacity to administer our persons and property;
- We are not related by family ties within the fourth degree of consanguinity nor within the second degree of affinity;<sup>7</sup>
- We have assumed mutual obligations for the welfare and support of each other;
- We have shared a common residence living as a couple under the same roof voluntarily, in a stable and continuous manner for a period of not less than one (1) year; and
- Our intention is to continue with the domestic partnership indefinitely.

Form: CSS-AS-10-002

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<sup>7</sup> This refers to family ties between parents, mothers-in-law, fathers-in-law, children, sons-in-law, daughters-in-law, grandparents, sisters-in-law, brothers-in-law, grandchildren, great-grandparents, uncles, aunts, nephews, nieces, great-grandchildren, and first cousins.

**Domestic Partnership Form/Inclusion of Dependents  
Under Individual Health Care Insurance Policy  
Page 2**

**Inclusion of Dependents**

As domestic partners, we are requesting that the dependent(s) of my domestic partner mentioned below be included in the policy. They are eligible due to their relationship with my domestic partner under the conditions set forth in the plan. Write legibly for each dependent of the domestic partner; name, initial, paternal and maternal surnames, and the relationship of the person with the domestic partner.

\_\_\_\_\_ (Dependent 1 of the Domestic Partner)  
 \_\_\_\_\_ (Dependent 2 of the Domestic Partner)  
 \_\_\_\_\_ (Dependent 3 of the Domestic Partner)  
 \_\_\_\_\_ (Dependent 4 of the Domestic Partner)

**Changes in the Domestic Partnership**

We acknowledge that if we no longer meet one or more of the criteria set forth above, we will no longer qualify as a Domestic Partnership and we will be under the obligation to submit to the insurer or health insurance organization within thirty days of the occurrence of the event a Termination of Domestic Partnership Form. We understand that after the termination of the domestic partnership, the domestic partner and any dependents thereof will lose their eligibility for coverage under this health insurance plan. In this case, the domestic partner and his or her dependents may choose another individual health insurance plan, as may be available.

**Information on the Insured and the Domestic Partner**

_____	_____
Name (please print)	Name (please print)
_____	_____
Social Security Number	Social Security Number
_____	_____
Date of birth	Date of birth
_____	_____
Residential Address	Residential Address
_____	_____
Mailing Address	Mailing Address
_____	_____
Signature	Signature
_____	_____
Date of signing of document	Date of signing of document

**NOTICE OF TERMINATION OF  
DOMESTIC PARTNERSHIP**

**Read these instructions carefully:**

The purpose of this sworn statement is to notify that the criteria to qualify as domestic partner for insurance coverage are no longer met. You do **NOT have to swear to this statement in the presence of an attorney-notary**. Your signature is sufficient to establish under oath that **everything that is set forth here is true**.

In the event that this document contains any inaccurate or untrue information, you are barred from signing this document.

Any person who knowingly and with the intention to defraud submits false information in an insurance application or who submits, assists in submitting or causes to be submitted a fraudulent claim for the payment of a loss or other benefit, will commit a felony, and if convicted, will be subject to a penalty for each violation of a fine of not less than five thousand dollars (\$5,000), nor greater than ten thousand dollars (\$10,000) or imprisonment for a fixed term of three (3) years, or both penalties. If there are aggravating circumstances, the established fixed penalty may be increased up to a maximum of five (5) years; and in the event of mitigating circumstances, may be reduced to a minimum of two (2) years.

**SWORN STATEMENT**

**Dissolution of Domestic Partnership**

A domestic partnership is terminated when:

- The persons who constitute the partnership cease to be the sole domestic partner of the other.
- The partner no longer shares the residence.
- When one of the persons in the couple dies.
- The couple does not live together in a stable and continuous manner.
- The couple does not intend to continue with the domestic partnership indefinitely.

I, \_\_\_\_\_ an insured under contract or policy number \_\_\_\_\_ issued by (name of the insurer or health insurance organization), certify that on or about \_\_\_\_\_, 20 \_\_\_\_\_, my relationship as a domestic partner of \_\_\_\_\_ (Domestic partner) ceased to comply with the requirements set forth in the Domestic Partnership Forms and that we will not be considered to be domestic partners according to the eligibility criteria of the health insurance plan.

I certify that I will send a copy of this Termination of Domestic Partnership Form to my former domestic partner at his or her last known address within ten (10) days from the signing of this statement to the following address:

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I understand that the effect of filing this Form is that the member of the domestic partnership, the person who is not the principal insured, will no longer have any right to the benefits that were extended through the principal insured, as the insured under the health insurance policy or plan. I understand and accept that if I comply with the requirements, I will not be able to submit another notification of domestic partnership form until the next renewal date of the health insurance plan.

**Information of the Insured Declarant**

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

Form: CSS-AS-10-003 (2)