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OFFICE OF THE HEALTH INSURANCE COMMISSIONER REGULATION 11
SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY REGULATION

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Section 1 ***Statement of Authority and Purpose***

This regulation is promulgated pursuant to the authority granted to the health insurance commissioner under R.I. Gen. Laws §§ 27-19-6, 27-20-6, 27-50-1 *et seq.*, 42-14-5, 42-14-17, 42-14.5-1 *et seq.*, 42-62-12, and 42-62-13.

This regulation is intended to implement the provisions of Title 27, Chapter 50, the “Small Employer Health Insurance Availability Act” (the “Act”). The purpose of the Act and this regulation is to provide for the availability of health insurance coverage to small employers and their employees and employees’ dependents, regardless of health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health benefit plans; to provide for uniform annual filing requirements by carriers participating in the small group health insurance market; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to direct the basis of market competition away from risk selection and toward the efficient management of health care; to provide for the availability of a wellness health benefit plan; to clarify the rules regarding the availability of individual health insurance policies to self employed-individuals and to improve the overall fairness and efficiency of the small group health insurance market.

The Act and this regulation are intended to promote broader spreading of risk in the small employer marketplace and to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of the Act and this regulation.

Section 2 ***Definitions***

All words or phrases used in this regulation already defined in R.I. Gen. Laws § 27-50-3 shall have the meaning therein. In addition, as used in this regulation:

- (a) “COBRA continuation coverage” means insurance continuation benefits provided under Title X of Pub. L. No. 99-272, as amended.
- (b) “Case characteristic” means the characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer.
- (c) “Commissioner” shall mean the health insurance commissioner.
- (d) “Covered employee” means an eligible employee who is or was provided coverage under a group health plan.
- (e) “Individual health insurance policy” means health insurance coverage offered to an individual in his or her capacity as an individual and not in connection with a group health benefit plan or as a small employer.
- (f) “New entrant” includes an eligible employee, or the dependent of an eligible employee, who becomes eligible to participate in a health benefit plan sponsored by a small employer in accordance with the special enrollment provisions under R.I. Gen. Laws § 27-50-7(d)(7) or (8).
- (g) “OHIC” or “Office” means the Office of the Health Insurance Commissioner.
- (h) “Qualified beneficiary” means, with respect to a covered employee under a group health plan, an individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan:
 - (1) as the spouse of the covered employee;
 - (2) as the dependent child of the covered employee, or
 - (3) a child who is born to or placed for adoption with the covered employee during the period of COBRA continuation coverage.
- (i) “Qualifying event” means, with respect to a covered employee, any of the following events that, but for COBRA continuation coverage, would result in the loss of coverage of a qualified beneficiary:
 - (1) the death of the covered employee;
 - (2) the termination, except for the employee’s gross misconduct, or reduction of hours, of the covered employee’s employment;
 - (3) the divorce or legal separation of the covered employee from the employee’s spouse;
 - (4) the covered employee becoming entitled to benefits under Title XVIII of the Social Security Act; or

- (5) a dependent child ceasing to be a dependent child under the requirements of the health benefit plan.
- (j) “Risk characteristic” means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

Section 3 Applicability and Scope

(a) Applicability.

- (1) Except as provided in paragraphs (a)(2) or (a)(3) of this section and Section 11 of this regulation, this regulation shall apply to any health benefit plan, whether provided on a group or individual basis, that:
 - (A) meets one or more of the conditions set forth in R.I. Gen. Laws § 27-50-4(a); and
 - (B) provides coverage to one or more employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state.
- (2) Individual health insurance; self-employed persons; plans and deductions under the Internal Revenue Code.
 - (A) The provisions of the Act and this regulation shall not apply to an individual health insurance policy purchased by a self-employed person for himself or herself alone or for that person and his or her spouse and/or family under conditions that do not meet those set forth in R.I. Gen. Laws § 27-50-4(a).
 - (B) In the case of a self-employed person, the conditions set forth in R.I. Gen. Laws § 27-50-4(a)(4) have been met if:
 - (i) the health insurance is marketed to the self-employed person in his or her capacity as a self-employed person; or
 - (ii) the health insurance is marketed to the self-employed person through that person’s membership (or potential membership) in an association or trade group for small employers or self-employed persons.
 - (C) A policy that otherwise meets the requirements of an individual health insurance policy and does not fall under the provisions of the Act and this regulation shall not be considered to have met the requirement of R.I. Gen. Laws § 27-50-4(a)(3) and therefore shall not be subject to the Act and this regulation solely because:
 - (i) the policyholder treats the health insurance policy as part of a plan or program under Section 125 of the Internal Revenue Code; provided however, that no portion of the premium is paid by the small employer through such a plan or program; or
 - (ii) the policyholder elects a deduction under section 162(l) of the Internal Revenue Code.

- (3) The provisions of the Act and this regulation shall apply to dental, vision or long term care benefits only as provided for in 45 C.F.R. 146.145.
- (b) Relationship to individual health insurance.
 - (1) Except as provided in paragraph (a)(2) of this section, a carrier that provides individual health insurance policies to one or more of the employees of a small employer shall be considered a small employer carrier and shall be subject to the provisions of the Act and this regulation with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware or should have been aware of such contribution.
 - (2) In the case of a carrier that provides individual health insurance policies to one or more employees of a small employer, the small employer shall be considered to be an eligible small employer as defined in R.I. Gen. Laws § 27-50-3(kk) and the small employer carrier shall be subject to R.I. Gen. Laws § 27-50-7(b) (relating to guaranteed issue of coverage) if:
 - (A) the employer qualifies as a small employer under the definitions contained in R.I. Gen. Laws §§ 27-50-3 and 27-50-7;
 - (B) the small employer contributes directly or indirectly to the premiums charged by the carrier; and
 - (C) the carrier is aware or should have been aware of the contribution by the employer.
- (c) Association or discretionary groups. The provisions of the Act and this regulation shall apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.
- (d) Number of eligible employees.
 - (1) If a small employer is issued a health benefit plan under the terms of the Act, the provisions of the Act and this regulation shall continue to apply to the health benefit plan even in the event that the small employer subsequently employs more than fifty eligible employees. A carrier providing coverage to such an employer shall, within sixty days of becoming aware that the employer has more than fifty eligible employees, but no later than the anniversary date of the employer's health benefit plan, notify the employer that the provisions and protections provided under the Act and this regulation shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

- (2) If a health benefit plan is issued to an employer that is not a small employer as defined in the Act, but subsequently the employer becomes a small employer (for any reason including the loss or change of work status of one or more employees), the terms of the Act shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier under the terms of the Act solely because the carrier continues to provide coverage under the health benefit plan to the employer. A carrier providing coverage to such an employer shall, within sixty days of becoming aware that the employer has fifty or fewer eligible employees, notify the employer of the options and protections available to the employer under the Act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier.
- (e) Employees outside of Rhode Island.
- (1) If a small employer has employees in more than one state, the provisions of the Act and this regulation shall apply to a health benefit plan issued to that small employer if:
 - (A) the majority of eligible employees of such small employer are employed in this state; or
 - (B) the primary business location of the small employer is in this state and no state has a majority of the eligible employees of the small employer.
 - (2) In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in paragraph (e)(1) of this section, the provisions of paragraph (e)(1) shall be applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect.
 - (3) If a health benefit plan is subject to the Act and this regulation, the provisions of the Act and this regulation shall apply to all individuals covered under the health benefit plan, whether they reside in this state or in another state.
- (f) Small employer carriers not operating in Rhode Island. A carrier that is not operating as a small employer carrier in this state shall not become subject to the provisions of the Act and this regulation solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state.

Section 4 Transition or Assumption of Business from Another Carrier

- (a) Approval required for transfer or assumption insurance risk. A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless:
- (1) the transaction has been approved by the insurance commissioner of the state of domicile of the assuming carrier or the OHIC if the assuming carrier is domiciled in Rhode Island;
 - (2) the transaction has been approved by the insurance commissioner of the state of domicile of the ceding carrier or the OHIC if the ceding carrier is domiciled in Rhode Island; and

- (3) the transaction otherwise meets the requirements of the Act and this regulation.
- (b) Approval of the transaction—carriers domiciled in Rhode Island. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation or risk of one or more small employer health benefit plans from another carrier shall make a filing for approval with the health insurance commissioner at least sixty days prior to the date of the proposed assumption. The commissioner may approve the transaction if the commissioner finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this regulation. The commissioner shall not approve the transaction until at least thirty days after the date of the filing, unless the ceding carrier is in hazardous financial condition. If the ceding carrier is in hazardous financial condition, the commissioner may approve the transaction as soon as the commissioner deems appropriate after the filing.
- (c) Requirements for the filing. The filing required under paragraph (b) of this section shall:
 - (1) describe whether the health benefit plans being assumed are currently available for purchase by small employers;
 - (2) describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed;
 - (3) describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed;
 - (4) describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed; and
 - (5) include any other information required by the health insurance commissioner.
- (d) Informational filing required in other states. A small employer carrier required to make a filing under paragraph (b) of this section shall also make an informational filing with the insurance commissioner of each state in which there are small employer health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under paragraph (b) of this section and shall include at least the information specified in paragraph (c) of this section for the small employer health benefit plans in that state.
- (e) Notice of the transaction—carriers not domiciled in Rhode Island. A small employer carrier not domiciled in Rhode Island shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless it has provided a notice to the health insurance commissioner at least sixty days prior to the date of the proposed assumption that contains the information specified in paragraph (c) of this section for the health benefit plans covering small employers in this state.
- (f) Transfer. A small employer carrier making a transfer pursuant to this section may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier into which the health benefit plans have been transferred.
- (g) New rate for transfers. The premium rate for an assumed small employer health benefit plan shall not be modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to this section. Upon transfer, the assuming small employer

carrier shall calculate a new premium rate for the health benefit plan from the rate manual required under Section 5 of this regulation.

- (h) Eligibility requirements may not be more stringent. An assuming carrier may not apply eligibility requirements, including minimum participation and contribution requirements, with respect to an assumed health benefit plan or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan that are more stringent than the requirements applicable to such health benefit plan prior to the assumption.
- (i) Legal obligations, authorizations and protections. Nothing in this section or in the Act is intended to:
 - (1) reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in R.I. Gen. Laws §§ 27-53.1-1 *et seq.* of the ceding or assuming carrier related to the transaction;
 - (2) authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or
 - (3) reduce or diminish the protections related to an assumption reinsurance transaction provided in R.I. Gen. Laws §§ 27-53.1-1 *et seq.* or otherwise provided by law.

Section 5 **Rate Manual and Restrictions Relating to Premium Rates**

- (a) Rate manual. A small employer carrier shall develop a rate manual based on an adjusted community rate and may only vary the adjusted community rate for the following case characteristics:
 - (1) age;
 - (2) gender; and
 - (3) family composition.
- (b) Age brackets. The adjustment for age in subsection (a) of this section may not use age brackets smaller than five (5) year increments. These brackets shall begin with age thirty (30) and end with age sixty-five (65).
- (c) Separate rates for individuals age sixty-five or older. A small employer carrier is permitted to develop separate rates for individuals age sixty-five (65) or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates are subject to the requirements of R.I. Gen. Laws § 27-50-5(a).
- (d) Four-to-one compression. For each health benefit plan offered by a carrier, the highest premium rate for each family composition type shall not exceed four (4) times the premium rate that could be charged to a small employer with the lowest premium rate for that family composition type.
- (e) Premium rates for bona fide associations except for the Rhode Island Builders Association whose membership is limited to those who are actively involved in supporting the construction industry in Rhode Island shall comply with the requirements of R.I. Gen. Laws §§ 27-50-5.

- (f) Carriers that provide coverage to the Rhode Island Builders Association must take steps to ensure that subscribers in the Builders Association block of business are limited to:
1. Persons actively engaged in the business of building, repairing, rehabilitating, adding onto, or upgrading homes, apartments, and other structures; the repairing, rehabilitating, additions or upgrading of property;
 2. Persons who are employed at least 30 hours per week by entities or persons in the business of building, repairing, rehabilitating, adding onto, or upgrading homes, apartments, and other structures; the repairing, rehabilitating, additions or upgrading of property;¹
 3. Suppliers that derive at least 20 percent of their gross annual revenue from sales to persons or entities actively in the business of building, repairing, rehabilitating, adding onto, or upgrading homes, apartments, and other structures; the repairing, rehabilitating, additions or upgrading of property;
 4. Subcontractors who derive at least 20 percent of their gross annual revenue from the provision of their services to persons or entities actively in the business of building, repairing, rehabilitating, adding onto, or upgrading homes, apartments, and other structures; the repairing, rehabilitating, additions or upgrading of property; and
 5. Architects, engineers, accountants, lawyers or others who derive at least 20 percent of their gross annual revenue from the provision of their professional services to persons or entities actively in the business of building, repairing, rehabilitating, adding onto, or upgrading homes, apartments, and other structures; the repairing, rehabilitating, additions or upgrading of property.
- (g) Carriers that provide coverage to the Rhode Island Builders Association must rate that group consistent with the carrier's rate manual, consistent with standard actuarial practices, and consistent with the purposes of the Act.
- (h) For a small employer group renewing its health insurance with the same small employer carrier which provided it small employer health insurance in the prior year, the combined adjustment factor for age and gender for that small employer group will not exceed one hundred twenty percent (120%) of the combined adjustment factor for age and gender for that small employer group in the prior rate year.
- (i) Family composition. Each small employer carrier shall include all categories of family composition set forth in the Act in each health benefit plan offered to every small employer. Those categories are (1) the enrollee; (2) the enrollee, spouse and children; (3) the enrollee and spouse; or (4) the enrollee and children.

¹ Consistent with R.I. Gen laws 27-50-3(m), employees who work on a a full-time basis for entities or persons in the business of building, repairing, rehabilitating, adding onto, or upgrading homes, apartments, and other structures; the repairing, rehabilitating, additions or upgrading of property with a normal work week of at least seventeen and one-half hours may be included by an employer, so long as this eligibility criterion is applied uniformly among all employees.

- (j) Small employer carriers shall apply rating factors consistently with respect to all small employers. Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans. Two groups that are otherwise identical, but which have different prior year rate factors may, however, have rating factors that produce premiums that differ because of the requirements of subsection (h) of this Section.
- (k) Nothing in this Section shall be construed to prevent a group health plan and a health insurance carrier offering health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, including those included in affordable health benefit plans, provided that the resulting rates comply with the other requirements of this Section. The calculation of premium discounts, rebates, or modifications to otherwise applicable copayments or deductibles for affordable health benefit plans shall be made in a manner consistent with accepted actuarial standards and based on actual or reasonably anticipated small employer claims experience. As used in the preceding sentence, “accepted actuarial standards” includes actuarially appropriate use of relevant data from outside the claims experience of small employers covered by affordable health plans, including, but not limited to, experience derived from the large group market, as this term is defined in R.I. Gen. Laws § 27-18.6-2(19).
- (l) Requirement to maintain rating information. In accordance with R.I. Gen. Laws § 27-50-5(h), a small employer carrier shall maintain rating information and documentation relating to rating practices and renewal underwriting practices and make it available to the health insurance commissioner. Such information shall be provided to the commissioner within ten days of a written request, provided however, the commissioner may, in his discretion, provide for an extension of time upon a showing of good cause by the carrier. The small employer carrier is not required to file such information with the commissioner for approval prior to use.
- (m) Rates computed solely from the rate manual. Except as provided in R.I. Gen. Laws § 27-50-5(a)(5), base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier’s discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.
- (n) Relationship among the base premium rates. The rate manual, developed pursuant to this section, shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan.
- (o) Differences among base premium rates. Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans, except as otherwise specifically permitted under the Act, and shall not be based in any manner on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

- (p) No application fees; in general. Except as provided in paragraph (q) of this section, a premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge.
- (q) Applications fees charged; exception to the prohibition. A carrier may charge a separate fee with respect to a health benefit plan (but only one fee with respect to such plan) provided the fee is no more than five dollars per month per employee and is applied in a uniform manner to each health benefit plan.
- (r) Allocation of expenses—statutory plans. A small employer carrier shall allocate administrative expenses to any health benefit plans required to be offered by R.I. Gen. Laws § 27-50-1 *et seq.* on a no less favorable basis than expenses are allocated to other health benefit plans.
- (s) Allocation of administrative expenses—the rate manual. The rate manual developed pursuant to this section shall describe the method of allocating administrative expenses to the health benefit plans for which the manual was developed.
- (t) Retention of rate manuals. The rate manual developed pursuant to this section shall be maintained by the carrier for a period of six years. Updates and changes to the manual shall be maintained with the manual.
- (u) Compliance with guidance. The rate manual and rating practices of a small employer carrier shall comply with all guidelines issued by the health insurance commissioner, including those issued pursuant to bulletins and orders adopting market conduct examination reports.
- (v) Employer does not meet “small employer” definition. If an employer does not meet the definition of a “small employer” under R.I. Gen. Laws § 27-50-3(kk), the small employer carrier shall rate the employer as a large employer, and the provisions of R.I. Gen. Laws § 27-50-5 and this section shall not apply.
- (w) Small employer carriers must provide to each employer, at the time of renewal of the employer’s plan, a Renewal Explanation Form with information describing the renewal rate calculation and the reasons for any changes in premiums. Small employer carriers must also provide the applicable Form upon the request of individual beneficiaries. The carrier must use a form substantially similar to the form set forth in Appendix J.

Section 6 Requirement to Insure Entire Group

- (a) Coverage for each eligible employee and dependent. A small employer carrier that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in paragraph (b) of this regulation, the small employer carrier shall provide the same health benefit plan to each such employee and dependent.
- (b) Offering one or more health benefit plans. A small employer carrier may offer the employees of a small employer the option of choosing one or more health benefit plans, provided that each employee may choose any of the offered plans. Except as provided in R.I. Gen. Laws § 27-50-7(d) (with respect to exclusions for preexisting conditions), the

choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics or a health status-related factor of the employees or their dependents.

- (c) List of eligible employees and dependents. A small employer carrier shall require each small employer that initially applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees as defined in R.I. Gen. Laws § 27-50-3(m). The small employer carrier shall require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) to verify the information required hereunder. Thereafter, eligibility documentation shall only be required for new employees and/or dependents who apply for coverage. Complete recertification of all eligible employees and dependents, or recertification of a particular employee and/or dependent may be required by the carrier at any time.
- (d) Waivers.
 - (1) A small employer carrier shall obtain a waiver from each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer.
 - (2) The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan.
 - (3) The waiver form shall:
 - (A) require that the reason for declining coverage be stated on the form;
 - (B) include a written warning of the penalties imposed on late enrollees;
 - (C) include a statement informing the eligible employee of their special enrollment rights, if any, under R.I. Gen. Laws § 27-50-7(d)(7) or (8); and
 - (D) include the model description of special enrollment rights contained in Appendix A, or a substantially similar description.
 - (4) In the event that an eligible employee or dependent refuses to sign the waiver required hereunder, the small employer must certify such refusal in writing.
 - (5) Waivers and certifications of refusal to sign waivers shall be maintained by the small employer carrier for a period of six years.
- (e) Refusal to provide the list of eligible employees and dependants. A small employer carrier shall not issue coverage (either new coverage or renewal coverage) to a small employer that refuses to provide the list of eligible employees and dependants pursuant to paragraph (c) of this section or a waiver required under paragraph (d) of this section. If a small employer fails to supply adequate supporting documentation, the carrier is required to presume that the employer is not eligible for issuance or renewal of coverage as a small employer. Individuals whose small employer benefits are declined or non-renewed shall be offered conversion, continuation or individual coverage as required under other applicable laws and regulations.

- (f) Extended medical leave. Small employer carriers must provide coverage for employees of a small employer on extended medical leave consistent with the requirements of chapter 18.7 of chapter 27 of the general laws.

Section 7 Application to Reenter State

- (a) Petition to be reinstated. A carrier that has been prohibited from writing coverage for small employers in this state pursuant to R.I. Gen. Laws § 27-50-6(c) may not resume offering health benefit plans to small employers in this state until the carrier has filed a petition with the health insurance commissioner seeking to be reinstated as a small employer carrier and the petition has been approved by the commissioner. In reviewing a petition to reinstate, the commissioner may ask for such information and assurances as the commissioner deems reasonable and appropriate.
- (b) Carrier doing business in only one established geographic service area. In the case of a small employer carrier doing business in only one established geographic service area of the state, if the small employer carrier elects to discontinue offering a health benefit plan under R.I. Gen. Laws § 27-50-6(a)(5), the small employer carrier shall be prohibited from offering health benefit plans to small employers in any part of the service area for a period of five years beginning on the date the carrier ceased offering new coverage in that established geographic service area of the state. In addition, the small employer carrier shall not offer health benefit plans to small employers in any other geographical area of the state without the prior approval of the health insurance commissioner. In considering whether to grant approval to offer health benefit plans, the commissioner may ask for such information and assurances as the commissioner deems reasonable and appropriate.

Section 8 Certification and Disclosure of Prior Creditable Coverage

- (a) Creditable coverage.
 - (1) In general.
 - (A) Small employer carriers shall provide written certification of creditable coverage, as that term is defined in R.I. Gen. Laws § 27-50-3(i), to individuals in accordance with this section.
 - (B) A small employer carrier shall be deemed to have satisfied the certification requirements of this section if another person provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period has been provided by the other person.
 - (C) To the extent coverage under a health benefit plan consists of group health benefit plan coverage, the plan shall be deemed to have satisfied the certification requirements of this section if the small employer carrier offering the coverage is required to provide the certificates of creditable coverage to individuals pursuant to an agreement between the plan and the carrier.
 - (D) A small employer carrier is not required to provide information regarding health benefit plan coverage provided to an individual by another person.
 - (E) If an individual's coverage under a policy ceases before the individual's coverage under the group health plan ceases, the entity that issued the policy shall provide sufficient information to the small employer carrier, or to another

person designated by the carrier, to enable the carrier, or other person, to provide a certificate that reflects the period of coverage under the policy, after the individual's coverage under the group health plan ceases.

- (i) The provision of the information pursuant to paragraph (a)(1)(E) of this section to the carrier shall satisfy the entity's obligation to provide an automatic certificate pursuant to paragraphs (a) and (b) of this section.
- (ii) The entity providing the information pursuant to paragraph (a)(1)(E) of this section shall cooperate with the carrier in responding to any request made under paragraph (f)(2) of this section.
- (iii) If the individual's coverage under the group health plan ceases at the time the individual's coverage under the policy ceases, the entity that issued the policy shall provide an automatic certificate pursuant to paragraphs 8(a)(2) or (3) of this section.
- (iv) An entity that issued the policy may presume that an individual whose coverage ceases at a time other than the effective date for changing enrollment options has ceased to be covered under the group health plan.

(2) Certification of creditable coverage.

- (A) A small employer carrier shall provide a certification of creditable coverage, without charge, to eligible employees or dependents who are or were covered under the group health plan as follows:
 - (i) for an individual who is a qualified beneficiary entitled to elect COBRA continuation coverage, automatically at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage; or
 - (ii) for an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, automatically at the time the individual ceases to be covered under the group health plan.
- (B) A small employer carrier satisfies the requirements of paragraph (a)(2)(A)(i) of this section if the carrier provides the certificate no later than the time a notice is required to be furnished for a qualifying event as specified in federal regulations.
- (C) A small employer carrier satisfies paragraph (a)(2)(a)(ii) of this section if the carrier provides the certification within a reasonable time after coverage under the group health plan ceases.
- (D) For an individual who is entitled to elect to continue coverage under a state program similar to COBRA and who receives the certificate pursuant to paragraph (a) (2)(a)(ii) of this section not later than the time a notice is required to be furnished under the state program, the certification shall be deemed to be provided within a reasonable time period after the cessation of coverage under the plan.

- (3) COBRA continuation coverage.
 - (A) For an individual who is a qualified beneficiary and has elected COBRA continuation coverage, or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage, a small employer carrier shall provide a certificate automatically at the time the individual's COBRA continuation coverage under the plan ceases.
 - (B) A small employer carrier satisfies paragraph (a)(3)(a) of this section if the carrier provides the certificate within a reasonable time after the coverage ceases or after the expiration of any grace period for nonpayment of premiums.
 - (C) A small employer carrier shall provide a certificate under paragraph (a)(3)(a) of this section to an individual regardless of whether the individual previously has received a certificate under paragraph(a)(2)(a)(i) of this section.
- (4) Request for a certificate.
 - (A) Procedure.
 - (i) A small employer carrier shall provide a certificate at the time a request is made by or on behalf of an individual if the request is made within twenty-four months after the date the individual's coverage has ceased under the plan.
 - (ii) Each small employer carrier shall establish a reasonable procedure for individuals to request and promptly receive certificates hereunder.
 - (B) Upon receipt of the request, the small employer carrier shall provide the certificate by the earliest date that the carrier, acting in a reasonable and prompt fashion, can provide the certificate.
 - (C) A small employer carrier shall provide a certificate as required under this Regulation even if the individual previously received such a certificate.
- (b) Requirements.
 - (1) Certificate must be in writing; exceptions.
 - (A) Except as provided in paragraph (b)(1)(B) of this section, a certificate provided under paragraph (a) of this section shall be in writing.
 - (B) A written certificate is not required to be provided pursuant to paragraphs (a)(2), (3), or (4) of this section if:
 - (i) an individual is entitled to receive a certificate;
 - (ii) the individual requests that the certificate be sent to another health benefit plan instead of the individual;
 - (iii) the health benefit plan that would otherwise receive the written certificate agrees to accept the information described in Section(8)(b)(2) through means other than a written certificate; and

- (iv) the receiving health benefit plan receives the information from the sending health benefit plan in such form within the time periods required under paragraphs (a)(2), (3), or (4) of this section.
- (2) A certificate provided pursuant to this paragraph (b) of this section shall include the following:
 - (A) the date the certificate was issued;
 - (B) the name of the group health plan that provided the coverage described in the certificate;
 - (C) the name of the participant and/or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for, or includes, a dependent;
 - (D) the name, address, and telephone number of the plan administrator required to provide the certificate;
 - (E) the telephone number to call for further information regarding the certificate if different from the phone number of the plan administrator;
 - (F) either:
 - (i) a statement that the individual has at least eighteen months of creditable coverage, disregarding days of creditable coverage before a significant break in coverage; or
 - (ii) the date any waiting period or affiliation period, if applicable, began and the date creditable coverage began; and
 - (G) the date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.
- (3) If an automatic certificate is provided pursuant to paragraph (a)(2) or (3) of this section, the period included on the certificate shall be the last period of continuous coverage ending on the date the coverage ceased.
- (4) For a certificate requested pursuant to paragraph (a)(4) of this section, the certificate must be provided for each period of continuous coverage ending within the twenty-four month period ending on the date of the request or continuing on the date of the request. A separate certificate may be provided for each period of continuous coverage.
- (5) A certificate may provide the information required pursuant to paragraph (b)(2) of this section with respect to both a participant and the participant's dependents if the information is identical for each individual. If the information required pursuant to paragraph (b)(2) of this section is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.
- (6) Appendix B contains a model certificate that a small employer carrier may use to satisfy the requirements of paragraph (b)(2) of this section.

- (7) A small employer carrier is not required to provide a certificate with respect to excepted benefits, as described in R.I. Gen. Laws § 27-50-3(v)(2), (3), (4) and (5), except if the excepted benefits are being provided concurrently with other creditable coverage. Under such circumstances, a small employer carrier may be required to disclose information concerning the benefits under paragraph (f) of this section.
- (c) Providing the certificate of coverage.
 - (1) Small employer carriers may provide a certificate required to be provided pursuant to this section by first-class mail.
 - (2) The address where the certificate is sent.
 - (A) If a small employer carrier provides the certificate or certificates to the participant and the participant's spouse at the participant's last known address, the carrier has satisfied the requirements of this Section with respect to all individuals residing at that address.
 - (B) If the last known address of a dependent of the participant is different from the participant's last known address, a small employer carrier shall provide a separate certificate to the dependent at the dependent's last known address.
 - (C) If a small employer carrier is providing separate certificates by mail to individuals who reside at the same address, the carrier is not required to mail each certificate separately.
 - (3) Designating another individual or person to receive the certificate.
 - (A) If a small employer carrier is required to provide a certificate automatically to an individual pursuant to paragraphs (a)(2) or (3) of this section, and the individual entitled to receive the certificate designates another individual or person to receive the certificate, the carrier may provide the certificate to the designated party.
 - (B) If a small employer carrier is required to provide a certificate upon request pursuant to paragraph (a)(4) of this section and the individual entitled to receive the certificate designates another individual or person to receive the certificate, the carrier shall provide the certificate to the designated party.
 - (d) Reasonable efforts.
 - (1) A small employer carrier shall use reasonable efforts to determine the information needed for a certificate relating to dependent coverage.
 - (2) For certificates required to be provided automatically pursuant to paragraphs (a)(2) or (3) of this section, an individual certificate is not required to be provided until the small employer carrier knows or, using reasonable efforts, should know of the dependent's cessation of coverage under the plan.

- (3) If a certificate provided by a small employer carrier does not provide the name of a dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph(g)(5) of this regulation for demonstrating dependent status. In addition, an individual may, if necessary, use the procedures described in paragraph (g)(5) of this section to demonstrate that a child was enrolled within thirty days of birth, adoption or placement for adoption.
- (e) Certificate provided for coverage not subject to the Act. Small employer carriers shall provide certificates of creditable coverage to individuals under this section even if the coverage is provided in connection with an entity or program that is not itself required to provide a certificate because the entity or program is not subject to the Act. This requirement applies to coverage provided in connection with: creditable coverage described in R.I. Gen. Laws § 27-50-3(j)(1)(b) through (j) and coverage subject to Section 2721(b)(1)(B) of the PHSA.
- (f) Alternative method of counting creditable coverage—information required. If an individual enrolls in a group health plan with respect to which the small employer carrier uses the alternative method of counting creditable coverage described in R.I. Gen. Laws § 27-50-7(d)(3) and the individual provides a certificate received pursuant to this section, at the request of the small employer carrier through which the individual has enrolled, the entity that provided the certificate to the individual shall promptly disclose to the carrier the information sufficient to identify to the small employer carrier the categories of benefits with respect to which the carrier is using the alternative method of counting creditable coverage. The small employer carrier requesting the information may identify specific information that the carrier reasonably needs in order to determine the individual's creditable coverage with respect to a category. The entity providing the information may charge the small employer carrier requesting the information for the reasonable cost of providing the information.
- (g) Establishing creditable coverage through other means.
 - (1) An individual may establish creditable coverage through means other than a certificate if:
 - (A) the accuracy of the certificate is contested; or
 - (B) a certificate is unavailable at the time the certificate is needed by the individual.
 - (2) Paragraph (g)(1) of this section applies, but is not limited to, the following circumstances:
 - (A) an entity has failed to provide a certificate within the required time period;
 - (B) the individual has creditable coverage, but an entity may not be required to provide a certificate under this section;
 - (C) the individual has an urgent medical condition that requires a determination as to creditable coverage prior to the time the individual can provide a certificate to the health benefit plan; or
 - (D) the individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

- (3) A small employer carrier shall take into account all of the information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion period.
- (4) A small employer carrier shall treat the individual as having provided a certificate pursuant to this section if the individual:
 - (A) attests to the period of creditable coverage;
 - (B) presents relevant corroborating evidence of some creditable coverage during the period; and
 - (C) cooperates with the carrier's efforts to verify the individual's coverage.
- (5) A small employer carrier may refuse to credit coverage where an individual fails to cooperate with the carrier's efforts to verify the individual's coverage. The carrier shall not consider the individual's inability to obtain a certificate as evidence of the absence of creditable coverage.
- (6) For the purpose of paragraphs (g)(4)(C) and (g)(5) of this section, "cooperate" includes providing, upon request of the small employer carrier, a written authorization for the carrier to request a certificate on behalf of the individual and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage.
- (7) Documents that may establish creditable coverage and waiting or affiliation periods in the absence of a certificate include:
 - (A) explanation of benefit (EOB) or other correspondence from a carrier indicating health benefit plan coverage;
 - (B) pay stubs showing a payroll deduction for health benefit plan coverage;
 - (C) a health insurance identification card;
 - (D) a certificate of coverage under a group health plan;
 - (E) records from health care providers, indicating health benefit plan coverage;
 - (F) third party statements verifying periods of health benefit plan coverage; and
 - (G) any other relevant documents that evidence periods of health benefit plan coverage.
- (8) In addition to documentation set out in paragraph (g)(7) of this section, creditable coverage and waiting or affiliation period information may be established through other means, such as by a telephone call from the carrier or provider to a third party verifying creditable coverage.
- (9) If, in the course of providing evidence of creditable coverage, including a certificate of creditable coverage pursuant to this section, an individual is required to demonstrate dependent status, the small employer carrier shall treat the individual as having furnished a certificate showing the dependent status if the individual:

- (A) attests in writing to the dependency and period of dependency; and
 - (B) the individual cooperates with the carrier's efforts to verify dependent status.
- (10) The procedures used by a small employer carrier pursuant to this section to determine creditable coverage shall apply to determine an individual's creditable coverage with respect to any category under paragraph (f) of this section relating to determining creditable coverage under the alternative method.
- (h) Determination of creditable coverage; preexisting condition exclusion.
- (1) Within a reasonable time period following the date of receiving information under this section with respect to creditable coverage of an individual, the small employer carrier shall make a determination regarding the individual's period of creditable coverage and notify the individual of the determination in accordance with the requirements of section (h)(3) of this section.
 - (2) Whether a determination and notification regarding an individual's creditable coverage is made within a reasonable time period shall be determined based on the relevant facts and circumstances, including whether the carrier's application of a preexisting condition exclusion would prevent the individual from having access to urgent medical care services.
 - (3) A small employer carrier seeking to impose a preexisting condition exclusion shall disclose, in writing, to the individual its determination of any preexisting condition exclusion period that applies to the individual and the basis for the determination, including the source and substance of any information on which the carrier relied in making the determination. A small employer carrier shall include in the disclosure an explanation of any appeal procedures established by the carrier and provide the individual with a reasonable opportunity to submit additional evidence of creditable coverage.
 - (4) Nothing in this paragraphs (g) or (h) of this section shall prevent a small employer carrier from modifying an initial determination of creditable coverage for an individual if the carrier determines that the individual did not have the creditable coverage, as claimed, if:
 - (A) the carrier provides a notice of reconsideration to the individual; and
 - (B) until the final determination regarding creditable coverage, the carrier, for the purpose of approving access to medical care, acts in a manner consistent with the initial determination.

Section 9 Restrictive Riders

A restrictive rider, endorsement or other provision that would violate the provisions of R.I. Gen. Laws § 27-50-7(d)(10)(iii) is prohibited. Furthermore, except as permitted in R.I. Gen. Laws § 27-50-7(d)(2), a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions or services otherwise covered by the plan.

Section 10 **Rules Related to Fair Marketing**

- (a) Marketing of health plans. A small employer carrier shall actively market each of its health benefit plans to small employers in this state, unless otherwise permitted or required by Rhode Island or federal law.
- (b) Offering health plans. A small employer carrier shall actively offer all health benefit plans it actively markets in this state to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier, unless otherwise permitted or required by Rhode Island or federal law. The offer may be provided directly to the small employer or delivered through a producer. The offer shall be in writing and shall include at least the following information:
 - (1) a general description of the benefits contained in any health benefit plans being offered to the small employer; and
 - (2) information describing how the small employer may enroll in the plans.
- (c) Price quote. A small employer carrier shall provide a price quote to a small employer directly or through an authorized producer within ten working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small employer directly or through an authorized producer within five working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.
- (d) Requirement to issue. Subject to R.I. Gen. Laws § 27-50-7(b)(2), a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan.
- (e) Use of group size or any health status to determine eligibility prohibited. A small employer carrier may not directly or indirectly use group size or any health status-related factor as criteria for establishing eligibility for a health benefit plan.
- (f) Toll-free number.
 - (1) A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state.
 - (2) The toll-free number shall be included in the local telephone directory and identified as a small employer health insurance contact number.
 - (3) The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.
- (g) Membership or contribution to association or group. The small employer carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement.

- (h) Requirement or condition to purchase other insurance. A small employer carrier may not require, as a condition of the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.
- (i) Initial determination of compliance with Act. Carriers offering individual and group health benefit plans in this state shall be responsible for initially determining whether the plans are subject to the requirements of the Act and this regulation. The final determination of compliance rests with the health insurance commissioner.
- (j) Required information from applicants. Carriers shall elicit the following information from applicants for such plans at the time of application:
 - (1) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and
 - (2) Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under Section 162 (other than Section 162(l)), Section 125 or Section 106 of the United States Internal Revenue Code.
- (k) Failure to collect information. If a small employer carrier fails to comply with paragraph (j) of this section, the small employer carrier shall be deemed to be on notice of any information that could reasonably have been obtained if the small employer carrier had complied with paragraph (j) of this section.

Section 11 Status of Carriers as Small Employer Carriers

- (a) Filing required. Each carrier providing health benefit plans in this state shall make a filing with the health insurance commissioner indicating whether the carrier intends to operate as a small employer carrier in this state under the terms of this regulation. There is no application form nor requirement for approval. A letter stating the carrier's intention to operate in Rhode Island as a small employer carrier is sufficient. If a carrier has already made such a filing with either the commissioner or the predecessor to the OHIC, the Department of Business Regulation, the carrier need not make a new filing.
- (b) Prohibition on providing coverage. Subject to paragraph (c) of this section, a carrier shall not offer health benefit plans to small employers, or continue to provide coverage under health benefit plans previously issued to small employers in this state, unless the filing provided pursuant to paragraph (a) of this section indicates that the carrier intends to operate as a small employer carrier in this state.
- (c) Exceptions. If the filing made pursuant paragraph (a) of this section indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to small employers in this state only if the carrier complies with the following provisions:
 - (1) the carrier complies with the requirements of the Act with respect to each of the health benefit plans previously issued to a small employer by the carrier;
 - (2) the carrier provides coverage to each new entrant to a health benefit plan previously issued to a small employer by the carrier; and

- (3) the carrier complies with the requirements of R.I. Gen. Laws § 27-50-15 and Sections 9 and 12 of this regulation as they apply to small employers whose coverage has been terminated by the carrier and to individuals and small employers whose coverage has been limited or restricted by the carrier.

For the purpose of paragraph (c)(2) of this section, the provisions of the Act and this regulation shall apply to the coverage issued to new entrants.

- (d) Five year prohibition exclusion from market. If the filing made pursuant to paragraph (a) of this section indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state, except as provided for in paragraph (c) of this section, for a period of five years from the date of the filing. Upon a written request from a carrier, the commissioner may reduce said period provided for in the previous sentence if the commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers and their employees in the state.

Section 12 Annual Filings

- (a) Annual filing required. A small employer carrier shall make three annual filings with the health insurance commissioner: (1) a rate/trend filing, (2) an actuarial certification, and (3) an informational filing. These filings must comply with the requirements of this section.
- (b) Rate/trend filing.
 - (1) No later than May 15 of each year, or at such other date specified by the Commissioner, each small employer carrier shall make an annual rate/trend filing that contains trend factors and other information in support of the rates proposed to be charged or a rating formula proposed to be used by the carrier in the small employer market for periods which do not already have approved rate factors. The trend filing shall conform to the template specified by the commissioner by bulletin and posted on the OHIC website. Upon receiving the filing, the commissioner shall make an initial review of the filing, and either (a) determine that the filing is complete, or (b) notify the carrier what additional information is needed for the filing to be determined to be complete. The commissioner shall notify each carrier once the filing is determined to be complete. In the commissioner's discretion, OHIC may send a copy of the carrier's completed filing to the department of the attorney general. Once the filing is determined to be complete, the commissioner shall issue a decision with respect to the filing in accordance with R.I. Gen. Laws §§ 27-19-6, 27-20-6, and 42-62-13. Nothing in this subdivision shall be construed to prevent a carrier from filing proposed rates or a rating formula in accordance with R.I. Gen. Laws §§ 27-19-6, 27-20-6, and 42-62-13 at other times when warranted under the circumstances.
 - (2) The commissioner may consult with such actuarial or other persons with relevant expertise employed by or under contract with OHIC or the department of business regulation. The written analysis conducted by such experts shall be entered into the record of the commissioner's review and distributed to the parties, and may be considered by the commissioner in making a decision with respect to the carrier's filing. Such written analysis shall also be entered into the evidentiary record of a hearing held under this section, and consistent with applicable law, including but not

limited to R.I. Gen. Laws §§ 42-35-9 and 42-35-13, may be considered by the commissioner or the commissioner's designee in connection with any final order following such hearing.

- (3) The rates proposed to be charged or the rating formula proposed to be used by a small employer carrier shall be based on a minimum projected loss ratio of eighty percent (80%). As used in this subdivision (3), "loss ratio" means the ratio calculated by dividing the carrier's health care claims experience by premium.
- (4) Decision by the commissioner; hearings.
 - (A) In accordance with the time periods established by with R.I. Gen. Laws §§ 27-19-6, 27-20-6, and 42-62-13, and after the commissioner determines the filing is complete,, the commissioner shall either (1) accept the filing, (2) make recommendations to the carrier as to how the filing should be amended, or (3) notice a hearing.
 - (i) If the commissioner recommends amendments to the filing, the carrier shall be provided with an opportunity to amend its filing in conformity to the recommended amendments. If the carrier amends its filing in conformity with the recommended amendments, the commissioner shall approve the filing.
 - (ii) If the carrier does not amend its filing, the commissioner shall notice a hearing on the filing determined to be complete. The hearing will be held within sixty days after the filing has been determined to be complete, upon not less than ten days prior written notice. The hearing notice shall contain a description of the rates proposed to be charged or the rating formula proposed to be used, and a copy of the notice shall be sent to the carrier and to the department of attorney general.
 - (iii) If the commissioner does not recommend amendments and determines that there should be a hearing, the hearing will be held within sixty days after the filing has been determined to be complete, upon not less than ten days prior written notice. The hearing notice shall contain a description of the rates proposed to be charged or the rating formula proposed to be used, and a copy of the notice shall be sent to the carrier and to the department of attorney general.
 - (B) At a hearing, the carrier shall be required to establish, in accordance with R.I. Gen. Laws sections §§ 27-19-6, 27-20-6, and 42-62-13, that the rates proposed to be charged or the rating formula proposed to be used are consistent with the proper conduct of its business, and with the interest of the public, and with all other applicable laws, regulations and orders of the commissioner.

- (C) Conduct of the hearing. The hearing shall be conducted in accordance with the R.I. Gen. Laws Title 42, chapter 35 (Administrative Procedures), and any orders as to the conduct of the hearing issued by the commissioner, or the commissioner's designee. The commissioner, or the commissioner's designee, may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance and require the production of all books, papers, records, correspondence, or other documents which he or she deems relevant. Any designee who shall conduct a hearing pursuant to this section shall report his or her findings in writing to the commissioner within eighty days of the date the filing was determined to be complete with a recommendation for approval, disapproval, or modification of the rates proposed to be charged or the rating formula proposed to be used by the applicant, unless the time for making such recommendation has been extended by agreement of the parties to the hearing. The recommended decision shall become part of the record. The commissioner shall make and issue a decision not later than ten days following the issuance of the recommended decision or, if the commissioner conducts the hearing without the appointment of a designee, as soon as is reasonably possible following the completion of the hearing. The decision may approve, disapprove, or modify the rates proposed to be charged or the rating formula proposed to be used by the carrier and may take into consideration any of this information required to be filed under this section.
- (D) Carriers shall underwrite the reasonable expenses incurred by the Office in connection with the hearing, including but not limited to any costs related to advertisements, stenographic reporting, expert witnesses fees, actuarial fees and the per diem cost of the designee as appointed by the commissioner.
- (E) The commissioner's designee shall mean a person who is impartial, a member in good standing of the Rhode Island bar and a person who is sufficiently acquainted with the rules of evidence as used in the superior court of the state so as to enable that person to conduct a hearing as designee of the commissioner.
- (F) A carrier that is aggrieved by the commissioner's decision after a hearing may move for reconsideration by the commissioner within twenty days of the date of the decision. The commissioner shall issue a decision on the motion for reconsideration within ten days of receiving the motion. Such motions may be granted by the commissioner for the following reasons: (1) mistake, inadvertence, surprise, or excusable neglect; (2) newly discovered evidence which by due diligence could not have been discovered in time for presentation at the hearing; (3) fraud, misrepresentation, or other misconduct of an adverse party; or (4) any other reason justifying relief from the decision. A party is not required to file a motion for reconsideration prior to appeal of the decision pursuant to R.I. Gen Laws § 42-35-15. However, if a carrier files a timely motion for reconsideration, carrier will not be considered to have fully

exhausted all administrative remedies until a decision has been issued by the commissioner on the motion.

(G) A carrier that is aggrieved by the commissioner's decision after exhausting all available administrative remedies is entitled to appeal the commissioner's decision in accordance with R.I. Gen. Laws § 42-35-15.

(H) A carrier may request a hearing on its filing at any time prior to a final decision by the commissioner to accept a filing or an amended filing.

(c) Actuarial certification.

(1) No later than March 15 of each year, each small employer carrier shall file an actuarial certification with the Office. The actuarial certification shall be made by an appointed actuary and shall certify that the carrier is in compliance with the Act and that the rating methods of the carrier are actuarially sound. The certification shall be in a form and manner specified by this regulation, shall contain the information required by this regulation and shall be signed by a qualified actuary. A copy of the certification shall be retained by the carrier at its principal place of business.

(2) Standard for actuarial certification and associated analysis.

(A) The certification shall be in the form of a written report, signed by the appointed actuary, and include such additional exhibits as may be required to support the conclusions and opinions stated in the certification. It should be prepared in accordance with Actuarial Standard of Practice No. 26 of the American Academy of Actuaries, "Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans," and shall contain a statement to that effect.

(B) The certification shall include, but not be limited to, the following areas of compliance:

(i) compliance with restrictions related to premium rates in R.I. Gen. Laws § 27-50-5;

(ii) compliance with provisions related to renewability of coverage in R.I. Gen. Laws § 27-50-6;

(iii) compliance with provisions related to availability of coverage in R.I. Gen. Laws § 27-50-7; and

(iv) compliance with provisions related to certification of creditable coverage in R.I. Gen. Laws § 27-50-8.

(C) The certification shall identify any instances of non-compliance in any of the above areas, and the number of instances of each type of non-compliance, the nature of the lack of compliance and the steps taken or recommended to correct non-compliance either retroactively or prospectively.

(D) The certification shall contain a statement describing the extent, if any, to which the appointed actuary relied upon the work of others in reaching his or her conclusions. If the appointed actuary has relied upon the work of others, a statement from the person or persons relied upon describing the accuracy and

completeness of the work shall be attached.

- (E) The appointed actuary shall maintain copies of all work papers necessary to support the conclusions reached in the certification for a minimum period of three years after the due date of the certification, and be prepared to explain the work done and/or produce the work papers to the commissioner or his or her designee upon request.
- (3) A qualified actuary is an individual who:
- (A) is a member in good standing of the American Academy of Actuaries;
 - (B) is familiar with the requirements applicable to carriers under the Act;
 - (C) is qualified to sign Prescribed Statements of Actuarial Opinion regarding compliance with small employer group health laws and regulations in accordance with the American Academy of Actuaries qualifications for actuaries signing such statements;
 - (D) has not been found by the commissioner or his or her designee (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing to have:
 - (i) violated any provision of, or any obligation imposed by, Rhode Island's insurance laws or other law in the course of his or her dealings as a qualified actuary;
 - (ii) been found guilty of fraudulent or dishonest practices;
 - (iii) demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as a qualified actuary;
 - (iv) submitted to the commissioner during the past five years, pursuant to the Act, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this regulation including standards set by the Actuarial Standards Board; or
 - (v) resigned or been removed as an actuary within the past five years as a result of actions or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and
 - (E) has not failed to notify the commissioner of any action taken by any insurance commissioner of any other state similar to those described above.
- (4) An "appointed actuary" is a qualified actuary who is appointed or retained to prepare the Statement of Actuarial Opinion required by R.I. Gen. Laws § 27-50-5(h), either directly by or by the authority of the board of directors through an executive officer of the carrier. The carrier shall give the commissioner not less than thirty days written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the carrier as an appointed actuary and shall state in such notice that the person meets the requirements set forth in this section. Once notice is furnished, no further notice is required with respect to this person, provided that the carrier shall give the

commissioner not less than thirty days written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in this section. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement and that the replacement actuary meets the requirements hereof.

(d) Informational filing

(1) No later than March 15 of each year, each small employer carrier shall file an informational filing with the Office. The informational filing shall contain the following information:

(i) the number of small employers that were issued health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);

(ii) the number of small employers that were issued the HEALTHpact plan in the previous calendar year (separated as to newly issued plans and renewals);

(iii) the following information, based on small employer health benefit plans in force as of December 31 of the previous calendar year, provided separately for HEALTHpact plans, and provided separately for each other category of plan issued by the carrier (i.e. PPO, POS, HMO, etc.). Each plan shall be identified by summary description and SERFF filing number:

(a) the number of small employer plans in force.

(b) the number of contracts.

(c) the number of members.

(iv) information related to the entire previous calendar year, provided separately for HEALTHpact plans, and provided separately for each other health benefit plan issued by the carrier, including:

(a) contract months insured.

(b) member months insured.

(c) collected premium.

(d) paid claims.

(v) information describing the efforts undertaken by the carrier to enhance the affordability of its products and implement policies and developments that improve the quality and efficiency of health care service delivery and outcomes in the state, as required by the commissioner; and

(vi) such other information as the commissioner determines is reasonable and necessary to carry out the purposes of the Act and this Regulation.

(e) Public availability of filings.

(i) Except for those documents or other information concerning which a party has requested, and the commissioner has approved confidential treatment, any information or documents contained in the filings or presented in support of the filings under this section shall be made available for public examination at any time and place that the commissioner may deem reasonable and shall ~~may~~ also be posted on the commissioner's web site.

(ii) The attorney general, when the attorney general is a party to an administrative hearing, and any other party to an administrative hearing shall be provided notice and an opportunity to be heard with respect to any request for confidential treatment of information. The commissioner may order that such parties to an administrative hearing may have access to confidential information subject to appropriate protective orders.

(iii) A request for confidential treatment of documents and other information shall be made in the following manner. The request must be made directly to the commissioner, with a copy of the request provided to the commissioner's legal counsel. The request must identify, and attach or enclose the specific documents or information for which confidential treatment is sought. The request must be accompanied by supporting factual and legal analysis with respect to (a) whether the specific information for which confidential treatment is requested satisfies the statutory criteria of a "trade secret" under R.I.Gen.Laws § 6-41-1, or the criteria of any other statute upon which the request for confidential treatment is based; and (b) whether the interests of the carrier in maintaining the confidentiality of the information outweighs the interests of the public in a transparent rate review process. See R.I.Gen.Laws. § 42-62-13. 4.

Section 13 Wellness Health Benefit Plan—The HEALTHpact Plan

- (a) Requirement to offer. Carriers that actively market health benefit plans to small employers in Rhode Island shall offer to those employers a wellness health benefit plan that meets the requirements of this section and complies with all other requirements of the Act and this regulation. Nothing in the Act or this regulation prohibits the sale of health benefit plans that differ from the wellness health benefit plans provided for in this section.
- (b) Effective date. Unless a carrier has received a waiver from the health insurance commissioner, all carriers that actively market health benefit plans to small employers in Rhode Island shall offer a wellness health benefit plan to small employers.
- (c) HEALTHpact. The wellness health benefit plan shall be referred to as the "HEALTHpact" plan.
- (d) Requirements of the HEALTHpact plan.
- (1) In general.
- (A) The HEALTHpact plan shall have two levels of benefits: Advantage and Basic.
- (B) Requirements for Advantage-level benefits are dependent on the member's age.

- (i) Members (including dependents) who are eighteen years of age or over at the time of enrollment or renewal are classified as “adult members” and are subject to the requirements for adult members.
 - (ii) Members who are between the ages of twelve and seventeen years of age at the time of enrollment or renewal are considered “adolescent members” and are subject to the requirements for adolescent members.
 - (iii) Members who are under the age of twelve at the time of enrollment or renewal are considered “child members” and are subject to the requirements for child members.
 - (C) The premium rates for the Advantage-level and Basic-level plans shall be the same, with Advantage-level members paying less for medical care, including but not limited to:
 - (i) lower copays for physician visits;
 - (ii) lower coinsurance for specific procedures;
 - (iii) lower annual deductibles; and
 - (iv) lower out-of-pocket maximums.
 - (D) Members who do not complete the requirements for Advantage-level benefits will receive Basic-level benefits. All members of a family must complete the Advantage-level requirements specified in paragraph (d)(2) of this section in order for the family to be eligible to receive Advantage-level benefits.
- (2) Different yearly requirements.
- (A) Requirements for Advantage-level benefits increase on a yearly basis over a period of two years.
 - (B) Year-one Advantage-level benefits are tied to the following requirements:
 - (i) for adult members, completion of the requirements set out in paragraph (d)(3)(A) of this section no later than twenty-one days prior to enrollment;
 - (ii) for adolescent members, completion of the requirements set out in paragraph (d)(3)(C) of this section no later than twenty-one days prior to enrollment; and
 - (iii) for child members, completion of the requirements set out in paragraph (d)(3)(E) of this section no later than twenty-one days prior to enrollment.
 - (C) Year-two Advantage-level benefits apply to year two and subsequent years, and are tied to the following requirements:
 - (i) for adult members, compliance with the requirements set out in paragraph (d)(3)(B) of this section no later than two hundred and forty days (eight months) from the date of enrollment;
 - (ii) for adolescent members, compliance with the requirements set out in paragraph (d)(3)(D) of this section no later than two hundred and forty days (eight months) from the date of enrollment; and

- (iii) for child members, compliance with the requirements set out in paragraph (d)(3)(F) of this section no later than two hundred and forty days (eight months) from the date of enrollment.

(3) Advantage-level requirements.

- (A) Each adult member must comply with specified wellness requirements for year-one Advantage-level benefits. These requirements include:

- (i) selection of a primary care physician (PCP);
- (ii) completion and submission of a Personal Health Assessment (PHA); and
- (iii) completion and submission of a HEALTHpact pledge.

A HEALTHpact pledge may be completed by an adult on behalf of all family members.

- (B) Each adult member must comply with specified wellness requirements for year-two Advantage-level benefits. These requirements include:

- (i) completion and submission of a PCP Checklist;
- (ii) completion and submission of a Participation Commitment Form (PCF), which specifies participation in a smoking cessation program, if necessary, and participation in a weight loss or weight management program, if necessary;
- (iii) participation in a disease management program (or programs), when identified for such a program (or programs) by the carrier; and
- (iv) participation in a case management program (or programs), when identified for such a program (or programs) by the carrier.

- (C) Each adolescent member must comply with specified wellness requirements for year-one Advantage-level benefits. These requirements include:

- (i) selection of a PCP; and
- (ii) completion and submission of a HEALTHpact pledge, unless a pledge is completed on behalf of an adolescent pursuant to paragraph (d)(3)(A) of this section.

- (D) Each adolescent member must comply with specified wellness requirements for year-two Advantage-level benefits. These requirements include:

- (i) completion and submission of a PCP Checklist;
- (ii) participation in a disease management program (or programs), when identified for such a program (or programs) by the carrier; and
- (iii) participation in a case management program (or programs), when identified for such a program (or programs) by the carrier.

- (E) Each child member must comply with specified wellness requirements for year-one Advantage-level benefits. These requirements include:

- (i) selection of a PCP.

- (F) Each child member must comply with specified wellness requirements for year-two Advantage-level benefits. These requirements include:
 - (i) participation in a disease management program (or programs), when identified for such a program (or programs) by the carrier; and
 - (ii) participation in a case management program (or programs), when identified for such a program (or programs) by the carrier.
- (e) Eligibility. Determination of Advantage-level versus Basic-level eligibility will be made by the carrier. Members will only move from one level of benefits to another (e.g., Advantage to Basic) on (1) the first day of the month following enrollment in the event the PHA is incomplete or (2) the enrollment anniversary date.
- (f) Forms and Documents.
 - (1) The enrollment package shall include the following forms and documents related to year-one Advantage-level eligibility:
 - (A) a year-one Advantage-level eligibility instruction sheet and checklist that substantially conforms to the model set out in Appendix C of this regulation;
 - (B) a HEALTHpact pledge form that substantially conforms to the model set out in Appendix D of this regulation.
 - (C) a form for selecting a PCP; and
 - (D) a PHA form.
 - (2) Carriers may develop and use their own PHA forms. The commissioner may, in consultation with the carriers, develop a standard PHA form for use with HEALTHpact plans.
 - (3) The forms and documents related to year-one Advantage-level eligibility shall be grouped together or otherwise conspicuously arranged so that members can readily identify all documents and forms necessary for eligibility for year-one Advantage-level benefits.
 - (4) The enrollment package shall include the following forms and documents related to year-two Advantage-level eligibility:
 - (A) a year-two Advantage-level eligibility instruction sheet and checklist that substantially conforms to the model set out in Appendix E of this regulation;
 - (B) PCP checklists that substantially conform to the models set out in Appendices G and H of this regulation;
 - (C) a sample Body Mass Index (BMI) chart that includes a statement that the sample BMI chart is for informational purposes only and that members should rely on their PCP rather than the sample BMI chart to determine their own BMI;
 - (D) statement that defines “smoke” or “smoking” as use of a tobacco product within the six month period prior to the completion of the PCP checklist; and
 - (E) an PCF that substantially conforms to the model set out in Appendix I of this regulation.

- (5) The forms and documents related to year-two Advantage-level eligibility shall be grouped together or otherwise conspicuously arranged so that members can readily identify all documents and forms necessary for eligibility for year-two Advantage-level benefits.
 - (6) Written copies of the forms and documents required by paragraph (f) of this section shall be made available to members upon request at no charge and shall, if possible, also be available on the carrier's website. Members shall also be informed that a photocopy of these form and documents, where possible, may be filled out and submitted to the carrier.
- (g) Rates.
- (1) The commissioner shall set an average annualized individual premium rate for the HEALTHpact plan to be less than ten percent of the average annual statewide wage, as reported by the Rhode Island department of labor and training, in their report entitled "Quarterly Census of Rhode Island Employment and Wages." In the event that this report is no longer available, or the commissioner determines that it is no longer appropriate for the determination of maximum annualized premium, an alternative method shall be adopted by the commissioner by regulation. The maximum annualized individual premium rate shall be determined no later than August 1st of each year, to be applied to the subsequent calendar year premium rates.
 - (2) Carriers must offer a HEALTHpact plan at a base community rate that is at or below the rate established pursuant to paragraph (g)(1) of this section and consistent with the requirement of Section of this regulation. Each carrier must receive approval of its annual HEALTHpact plan base community rate from the commissioner. Carriers may make adjustments to their HEALTHpact plan base community rate in accordance with the Act and Section 5 of this regulation.
 - (3) Carriers may increase their HEALTHpact plan base community rate throughout the year, but only as authorized by the commissioner.
- (h) Benefits to be offered.
- (1) The benefits to be provided in any HEALTHpact plan, by either new or renewal coverage commencing before October 1, 2008, shall be consistent with the guidance provided by the advisory committee established pursuant to R.I. Gen. Laws. § 27-50-10. This guidance is contained in the HEALTHpact plan requirements document, available from OHIC.
 - (2) The benefits to be provided in any HEALTHpact plan, by either new or renewal coverage commencing on or after October 1, 2008, shall be consistent with the guidance provided by the commissioner in an annual HEALTHpact plan requirements document. The procedures for establishing the annual plan requirements document guidance, including timeframes for the approval process, shall be specified by the commissioner in an OHIC bulletin, to be issued no later than May 1 of each year.
- (i) Appeals. Carriers shall develop and consistently apply an appeal mechanism for a member dissatisfied with his or her Basic-level benefits determination. Carriers may satisfy this requirement through the use of existing appeal processes and procedures.

- (j) Marketing.
 - (1) A small employer carrier shall actively market a HEALTHpact plan in accordance with R.I. Gen. Laws Section 27-50-7(b). Prior to offering a HEALTHpact plan, a carrier shall provide the commissioner with a copy of the carrier's initial marketing plan for its HEALTHpact plan.
 - (2) Except as provided by paragraph (1) of this section, a small employer carrier may not suspend the marketing or issuance of the HEALTHpact plan unless the carrier has good cause and has received the prior approval of the Commissioner.
 - (3) Any producer authorized by a small employer carrier to market health benefit plans to small employers in this state shall also be authorized to market the HEALTHpact plan.
 - (4) Carriers are free to use any name for the marketing of the HEALTHpact plan; however, a tagline identifying the wellness health benefit plan as a "HEALTHpact" plan shall be used by the carriers in all marketing materials related to the HEALTHpact plan. The insurers shall be free to name the HEALTHpact plan in accordance with its standard product naming process and conventions. Either the tagline or the logo shall appear on the health plan identification cards for the HEALTHpact plan in accordance with the style guide developed by the commissioner. The style guide is available from the OHIC and is posted on the OHIC website.
- (k) Dual option. The HEALTHpact plan must be offered on a dual option and sole replacement basis to all small group employers. "Offered" means at a minimum that every rate sheet from the insurer to a broker or a small group must include the HEALTHpact plan as an option. This requirement will be reevaluated in time for applications and renewals commencing no later than October 1, 2009. This dual option requirement will be reevaluated in terms of its impact on each carrier's HEALTHpact plan membership, loss ratio, and other relevant metrics.
- (l) Enrollment cap. Carriers may set an enrollment cap of no fewer than 5,000 HEALTHpact plan members. Once the cap is reached in a particular year, carriers may cease to offer the HEALTHpact plan for the remainder of the year. The cap may be reevaluated annually by the commissioner, with the first evaluation performed in time for applications and renewals commencing no later than October 1, 2009.
- (m) Time limits for participation requirements. The following timeline shall apply to all new and renewal applications for HEALTHpact plans:
 - (1) Distribution of enrollment or renewal packages. Enrollment or renewal packages containing the information, documents and forms required by this regulation for HEALTHpact plans shall be provided to employers, either directly by the carrier or through a broker, no later than forty-five days prior to the employer's expected enrollment or renewal date, unless not practicable.
 - (2) Completion and submission of year-one Advantage level eligibility requirements.
 - (A) In order to meet the requirements set out in section (d)(2)(B) of this regulation, members must forward to the carrier, either by mail (first class postage) or

delivery (by hand or by a third-party) the pledges, PCP selection forms and PHAs, as required by sections (d)(3)(A) (for adults), (d)(3)(C) (for adolescents), or (d)(3)(E) (for children), no later than twenty-one days prior to the enrollment date.

- (B) Members will meet the deadline required by section (d)(2)(B) of this regulation if the forms, if mailed, are postmarked on or before the twenty-first day prior to the enrollment date, or if delivered, are received by the carrier before the close of business on or before the twenty-first day prior to enrollment date.
 - (C) If the twenty-first day prior to enrollment date falls on a weekend or state or federal holiday, the deadline shall be extended by the carrier to the next business day.
- (3) Reminder card or letter. No later than one hundred and fifty days (five months) after enrollment, carriers shall send a reminder card or letter to members alerting members of the year-two Advantage-level requirements and deadlines.
- (4) Completion and submission of year-two Advantage level eligibility requirements. In order to be eligible for year-two Advantage-level benefits, members must:
- (A) Submit the PCP checklist no later than two hundred and forty days (eight months) after the enrollment date.
 - (B) Participate in case management and/or disease management programs no later than two hundred and forty days (eight months) after the enrollment date, if:
 - (i) selected by the carrier for case management and/or disease management programs; and
 - (ii) notified by the carrier of the case management and/or disease management programs no later than one hundred and eighty days (six months) after the enrollment date.
 - (iii) Members who are notified by the carrier of selection for case management and/or disease management programs after the deadline set out in paragraph (h)(4)(B)(ii) of this section, must nevertheless participate in the case management and/or disease management programs, however, this participation shall not affect the member's year-two Advantage-level eligibility, but shall affect the member's year-three (and subsequent) Advantage-level eligibility.
 - (C) Meet the requirements set out in section (d)(2)(B) of this regulation.
 - (1) In order to meet the requirements set out in section (d)(2)(C) of this regulation, members must forward to the carrier, either by mail (first class postage) or delivery (by hand or by a third-party) the PCP checklists and PCFs, as required by sections (d)(3)(B) (for adults) and (d)(3)(D) (for adolescents), to the carrier no later than two hundred and forty days (eight months) after the enrollment date.
 - (2) Members will meet the requirements set out in section (d)(2)(C) of this regulation if the forms, if mailed, are postmarked on or before the two

hundred and fortieth day after the enrollment date, or if delivered, are received by the carrier before the close of business on or before the two hundred and fortieth day after the enrollment date.

- (3) If the two hundred and fortieth day after the enrollment date falls on a weekend or state or federal holiday, the deadline shall be extended by the carrier to the next business day.

An example of the Advantage-level benefits timeline for adults with an October 1, 2007 enrollment date is as follows:

Number of days to/from enrollment	Action	Date
-45	Enrollment packages received by employer	8/17/2007
-21	Last day for employees to submit: (1) PCP selection form (2) Signed pledge (3) PHA form	9/10/2007
0	Enrollment date	10/1/2007
+150	Reminder card/letter sent by carrier for year-two Advantage-level requirements	2/28/2008
+180	Last day for carriers to notify subscribers of case management and/or disease management participation requirement in time to affect year-two Advantage eligibility.	3/31/2008
+180	Last day for PCP office visit to fill out PCP Checklist	4/28/2008
+240	Last day for members to participate in CM and DM, if necessary, to affect year-2 Advantage eligibility.	5/28/2008
+240	Last submission of the following to carriers: (1) PCP checklist and (2) PCF.	5/28/2008

- (n) Non-renewal date enrollment. Employers may switch from an existing product to the HEALTHpact plan with the same carrier earlier than the employers scheduled renewal

date, thereby changing their effective renewal date, at no penalty to the employer. Employers interested in purchasing the HEALTHpact plan but who are unable to complete the enrollment requirements within the required twenty-one days prior to their scheduled renewal date may extend their existing plan, unless the plan has been discontinued, for at least thirty days (one month) in order to allow sufficient time to complete the new enrollment requirements, at no penalty to the employer.

- (o) Network Requirements. Unless otherwise specified by the commissioner, the carriers shall develop a tiered network according to the deadlines in this section, that is, at minimum, based on quality measures. Each carrier's tiered network structure must be implemented for all new and renewal HEALTHpact plan members no later than October 1, 2008. OHIC rating decisions for rates applicable to October 1, 2008 and later will assume compliance with this requirement. Draft tiered network proposals to be implemented on October 1, 2008 must be submitted to OHIC on or before September 1, 2007. A final tiered network proposal must be submitted to OHIC on or before March 1, 2008. OHIC decisions regarding carrier proposals will be determined on or before April 1, 2008. OHIC decisions regarding future revisions/phased implementation of network proposals (after October 1, 2008) will be made in response to the final carrier proposals.
- (p) Bulletins. The commissioner may issue bulletins for clarification or additional guidance on the HEALTHpact plan. Carriers may also request guidance from the commissioner in the form of a bulletin.
- (q) Late enrollees (including added dependents).
 - (1) Enrollees who are either:
 - (A) offered participation in an employer's HEALTHpact plan less than twenty-one days prior to the enrollment date and who could not have completed the year-one Advantage-level requirements prior to twenty-one days before the enrollment date (e.g., because the employee had not yet been employed by the employer who offered the plan, the dependent had not yet been born, etc.); or
 - (B) added to an employer's HEALTHpact plan after the enrollment datewill receive year-one Advantage-level benefits, but must, at the time of enrollment, complete the standard requirements for year-one Advantage-level enrollees.
 - (2) To be eligible for year-two Advantage level-benefits, late enrollees must comply with the same disease and case management requirements as all other enrollees.
- (r) Switching carriers. If an employer switches carriers after enrolling in the HEALTHpact plan, the new carrier may require the employer's enrollees to meet the Advantage-level benefits requirements that would have been required of those enrollees had the employer remained enrolled in the HEALTHpact plan through the previous carrier.

OHIC Regulation 11: Small Employer Health Insurance Availability Regulation effective 11-14-2011.

Section 14 ***Severability***

If any provision of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected thereby.

Section 15 ***Effective Date***

This regulation and its amendments shall be effective on the date indicated below.

EFFECTIVE DATE: November 14, 2011

AMENDED: September 26, 2011

APPENDIX A

MODEL DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption.

APPENDIX B

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

***IMPORTANT** – This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____
2. Name of group health plan: _____
3. Name of participant: _____
4. Identification number of participant: _____
5. Name of any dependents to which this certificate applies: _____

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____

7. For further information, call: _____

8. If the individuals identified in line 3 and line 5 have at least 18 months of creditable coverage (disregarding periods of coverage before a 90-day break), check here (and skip lines 9 and 10).
9. Date waiting period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended: _____ (or check here if coverage is continuing as of the date of this certificate).

NOTE: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

APPENDIX C

MODEL INSTRUCTIONS FOR YEAR-ONE ADVANTAGE-LEVEL BENEFITS

HEALTHpact Plan [use standard brand format and logo]

***IMPORTANT** – In order to receive year-one Advantage-Level benefits (beginning at enrollment) in [insert product name, a HEALTHpact Plan], each adult (age 18 and over at the time of enrollment) must complete the following:

1. **HEALTHpact Pledge Form**
Every adult must complete and submit the [enclosed/attached] HEALTHpact Pledge Form twenty-one days prior to the enrollment date. The enrollment date is the date your coverage begins.
2. **Primary Care Physician (PCP) Selection Form**
Every adult must complete and submit the [enclosed/attached] PCP Selection Form twenty-one days prior to the enrollment date.
3. **Personal Health Assessment (PHA) Form**
Every adult must complete and submit the [enclosed/attached] PHA Form twenty-one days prior to the enrollment date.

In order to receive year-one Advantage-Level benefits (beginning at enrollment) in [insert product name, a HEALTHpact Plan], each adolescent (who is at least 12 but not older than 17 at the time of enrollment) must complete the following:

1. **HEALTHpact Pledge Form**
Every adolescent must complete and submit the [enclosed/attached] HEALTHpact Pledge Form twenty-one days prior to the enrollment date. The enrollment date is the date your adolescent's coverage begins.
2. **Primary Care Physician (PCP) Selection Form**
The [enclosed/attached] PCP Selection Form must be completed and submitted for every adolescent twenty-one days prior to the enrollment date.

In order to receive year-one Advantage-Level benefits (beginning at enrollment) in [insert product name, a HEALTHpact Plan], each child (who is under 12 at the time of enrollment) must complete the following:

1. Primary Care Physician (PCP) Selection Form

The [enclosed/attached] PCP Selection Form must be completed and submitted for every child twenty-one days prior to the enrollment date. The enrollment date is the date your child's coverage begins.

No HEALTHpact Pledge Form is required for children under 12.

Please use the attached checklist to ensure that all requirements have been met. Mail or deliver the checklist and all required forms to:

[insert carrier name and address]

no later than twenty-one days prior to enrollment. If we do not receive of these forms from each family member as required, the entire family shall receive Basic level benefits.

Additional forms are available at our website, at [insert web address]

Your 21 day deadlines are as follows:

If your enrollment date is:		21 days before enrollment is:
Monday, October 1, 2007	→	Monday, September 10, 2007
Thursday, November 1, 2007	→	Thursday, October 11, 2007
Saturday, December 1, 2007	→	Monday, November 12, 2007*
Tuesday, January 1, 2008	→	Tuesday, December 11, 2007
Friday, February 1, 2008	→	Friday, January 11, 2008
Saturday, March 1, 2008	→	Monday, February 11, 2008*
Tuesday, April 1, 2008	→	Tuesday, March 11, 2008
Thursday, May 1, 2008	→	Thursday, April 10, 2008
Sunday, June 1, 2008	→	Monday, May 12, 2008*
Tuesday, July 1, 2008	→	Tuesday, June 10, 2008
Friday, August 1, 2008	→	Friday, July 11, 2008
Monday, September 1, 2008	→	Monday, August 11, 2008
Wednesday, October 1, 2008	→	Wednesday, September 10, 2008

*The 21st day prior to the December, March and June dates falls on a weekend day and has therefore been advanced to the next Monday.

**HEALTHpact Plan [use standard brand format and logo]
Year-One Advantage-Level Benefits Checklist**

List of Adults (18 and over as of the date of enrollment):

1. _____
Name
 HEALTHpact Pledge Form completed and enclosed
 PCP Selection Form completed and enclosed
 PHA Form completed and enclosed
2. _____
Name
 HEALTHpact Pledge Form completed and enclosed
 PCP Selection Form completed and enclosed
 PHA Form completed and enclosed
3. _____
Name
 HEALTHpact Pledge Form completed and enclosed
 PCP Selection Form completed and enclosed
 PHA Form completed and enclosed
4. _____
Name
 HEALTHpact Pledge Form completed and enclosed
 PCP Selection Form completed and enclosed
 PHA Form completed and enclosed
5. _____
Name
 HEALTHpact Pledge Form completed and enclosed
 PCP Selection Form completed and enclosed
 PHA Form completed and enclosed

List of Adolescents (12 to 17 as of the date of enrollment):

1. _____
Name
 HEALTHpact Pledge Form completed and enclosed
 PCP Selection Form completed and enclosed
2. _____
Name
 HEALTHpact Pledge Form completed and enclosed
 PCP Selection Form completed and enclosed
3. _____
Name
 HEALTHpact Pledge Form completed and enclosed
 PCP Selection Form completed and enclosed
4. _____
Name
 HEALTHpact Pledge Form completed and enclosed
 PCP Selection Form completed and enclosed
5. _____
Name
 HEALTHpact Pledge Form completed and enclosed
 PCP Selection Form completed and enclosed

List of Children (under 12 as of the date of enrollment):

1. _____
Name
 PCP Selection Form completed and enclosed

2. _____
Name
 PCP Selection Form completed and enclosed

3. _____
Name
 PCP Selection Form completed and enclosed

4. _____
Name
 PCP Selection Form completed and enclosed

5. _____
Name
 PCP Selection Form completed and enclosed

APPENDIX D

MODEL HEALTHpact PLEDGE FORM

HEALTHpact Pledge Form

This plan focuses on primary care, prevention, and wellness. This plan also emphasizes the importance of proper treatment for the chronically ill. To support these goals, and to obtain the Advantage level of benefits, individuals and family members must pledge to commit to the goals of the HEALTHpact plan, as follows:

I, _____ (print member name), agree to:

- Participate in a smoking cessation program, if currently a smoker, or remain smoke-free if a non-smoker.
- Participate in a weight loss or weight management program, if I have a high Body Mass Index (BMI), or maintain a healthy weight if my BMI is in the healthy range.
- Participate in disease management or case management, if identified by [name of carrier] as an individual who would benefit from these programs.

Today is _____, 200__, and I understand my participation in the Advantage program is dependent on my engagement in the above mentioned programs.

Signed _____

(By the member if 18 or older as of the date of enrollment or the member's parent or guardian if the member is 12 to 17 years old)

No pledge is required of members under 12 years old.

Additional forms are available at our website, at [insert web address]

APPENDIX E

MODEL INSTRUCTIONS FOR YEAR-TWO ADVANTAGE-LEVEL BENEFITS

HEALTHpact Plan [use standard brand format and logo]

***IMPORTANT** – In order to retain Advantage Level benefits in Year-Two for [insert product name, a HEALTHpact Plan], each adult (age 18 and over at the time of enrollment) must complete the following:

1. Primary Care Physician Checklist (PCP Checklist)

Every adult must have the attached PCP checklist filled out by his/her primary care physician within 180 days (six months) of enrollment. This form is intended to identify smoking cessation and weight management goals for each member.

2. HEALTHpact Participation Commitment Form

Within 240 days (eight months) of enrollment, every adult must fill out the attached HEALTHpact Participation Commitment Form. This form is intended to conform each member's actions taken to comply with the wellness programs identified by his/her primary care physician in the PCP Checklist (related to smoking cessation and/or weight management).

In order to retain the Advantage Level benefits in Year-Two for [insert product name, a HEALTHpact Plan], each child who is at least 12 but not older than 17 at the time of enrollment must complete the following:

Primary Care Physician Checklist (PCP Checklist)

Every child must have the attached PCP checklist filled out by his/her primary care physician within 180 days (six months) of enrollment. This form is intended to identify smoking cessation and weight management goals for each member.

No HEALTHpact Participation Commitment Form is required for children aged 12 to 17.

No PCP Checklist or HEALTHpact Participation Commitment Form is required for children under 12.

Please use the attached checklist to ensure that all requirements have been met. Mail the checklist and all required forms to:

[insert carrier name and address]

no later than 240 days (eight months) after enrollment. If we do not receive of these forms from each family member as required within eight months of enrollment, the entire family shall receive Basic level benefits.

Additional forms are available at our website, at [insert web address]

Your 180 day deadlines are as follows:

If your enrollment date is:	→	180 days after enrollment is:
Monday, October 1, 2007	→	Monday, March 30, 2008*
Thursday, November 1, 2007	→	Tuesday, April 29, 2008
Saturday, December 1, 2007	→	Thursday, May 29, 2008
Tuesday, January 1, 2008	→	Monday, June 30, 2008*
Friday, February 1, 2008	→	Wednesday, July 30, 2008
Saturday, March 1, 2008	→	Thursday, August 28, 2008
Tuesday, April 1, 2008	→	Monday, September 29, 2008*
Thursday, May 1, 2008	→	Tuesday, October 28, 2008
Sunday, June 1, 2008	→	Friday, November 28, 2008
Tuesday, July 1, 2008	→	Monday, December 29, 2008*
Friday, August 1, 2008	→	Wednesday, January 28, 2009
Monday, September 1, 2008	→	Monday, March 2, 2009*
Wednesday, October 1, 2008	→	Monday, March 30, 2009

*The 180th day after the October, January, April, July, and September enrollment dates falls on a weekend day and has therefore been advanced to the next Monday.

Your 240 day deadlines are as follows:

If your enrollment date is:	→	180 days after enrollment is:
Monday, October 1, 2007	→	Wednesday, May 28, 2008
Thursday, November 1, 2007	→	Monday, June 30, 2008*
Saturday, December 1, 2007	→	Monday, July 28, 2008
Tuesday, January 1, 2008	→	Thursday, August 28, 2008
Friday, February 1, 2008	→	Monday, September 29, 2008*
Saturday, March 1, 2008	→	Monday, October 27, 2008
Tuesday, April 1, 2008	→	Thursday, November 27, 2008
Thursday, May 1, 2008	→	Monday, December 29, 2008*
Sunday, June 1, 2008	→	Tuesday, January 27, 2009
Tuesday, July 1, 2008	→	Thursday, February 26, 2009
Friday, August 1, 2008	→	Monday, March 30, 2009*
Monday, September 1, 2008	→	Wednesday, April 29, 2009
Wednesday, October 1, 2008	→	Friday, May 29, 2009

*The 240th day after the November, February, May, and August enrollment dates falls on a weekend day and has therefore been advanced to the next Monday.

**HEALTHpact Plan [use standard brand format and logo]
Year-Two Advantage-Level Benefits Checklist**

List of Adults (18 and over as of the date of enrollment):

1. _____
Name
 PCP Checklist completed and enclosed
 HEALTHpact Participation
Commitment Form completed and enclosed
2. _____
Name
 PCP Checklist completed and enclosed
 HEALTHpact Participation
Commitment Form completed and enclosed
3. _____
Name
 PCP Checklist completed and enclosed
 HEALTHpact Participation
Commitment Form completed and enclosed
4. _____
Name
 PCP Checklist completed and enclosed
 HEALTHpact Participation
Commitment Form completed and enclosed
5. _____
Name
 PCP Checklist completed and enclosed
 HEALTHpact Participation
Commitment Form completed and enclosed

List of Adolescents (12 to 17 as of the date of enrollment):

1. _____
Name
 PCP Checklist Completed and enclosed
2. _____
Name
 PCP Checklist Completed and enclosed
3. _____
Name
 PCP Checklist Completed and enclosed
4. _____
Name
 PCP Checklist Completed and enclosed
5. _____
Name
 PCP Checklist Completed and enclosed

APPENDIX F

[reserved]

APPENDIX G

PRIMARY CARE PHYSICIAN CHECKLIST FOR ADULTS (OVER 18 AT THE TIME OF ENROLLMENT)

HEALTHpact Plan [use standard brand format and logo] Primary Care Physician Checklist for Adults

***IMPORTANT** – In order to receive Advantage Level benefits in [insert product name, a HEALTHpact Plan], this form must be completed by your primary care physician (PCP) for each adult (age 18 and over at the time of enrollment) HEALTHpact member and mailed by the member to:

[insert carrier name and address]

no later than eight months (240 days) after enrollment. If we do not receive of these forms for all adult family member within 240 days of enrollment, the entire family shall receive Basic level benefits.

1. Member Name: _____
2. Address _____
3. Member Identification Number: _____
4. Date of Birth: _____
5. Date of examination: _____

Body Mass Index

6. Body Mass Index (BMI) calculation
 - a. Weight: _____
 - b. Height: _____
 - c. BMI: _____
7. The member's BMI is above his/her recommended BMI level: Yes No
8. If the member's BMI is above the recommended level, has the physician discussed a weight loss program or goal with the member? Yes No (leave blank if member's BMI is not above recommended level).
9. Briefly describe the program or goal: _____

10. Additional comments: _____

Smoking

11. Is the member a smoker (has he or she smoked at all within the last 6 months): Yes No
12. If the member is a smoker, has the physician discussed a smoking cessation program or goal with the member? Yes No (leave blank if member is not a smoker).
13. Briefly describe the program or goal: _____

14. Additional comments: _____

Physician Signature (Required)

The information supplied above is complete and accurate to the best of my knowledge.

Physician Signature: _____ Date: _____

Physician Name (printed): _____

Member Signature (Required)

I have reviewed and discussed the information supplied above with my physician and I agree to comply with his/her recommendations. I understand that submission of this PCP Checklist is required in order to continue in the Advantage level of benefits under my HEALTHpact plan. I further understand that I am required to submit a Participation Commitment Form documenting my compliance with my physicians' recommendations.

Member Signature: _____ Date: _____

Additional forms are available at our website, at [insert web address]

APPENDIX H

PRIMARY CARE PHYSICIAN CHECKLIST FOR ADOLESCENTS (12-17 AT THE TIME OF ENROLLMENT)

HEALTHpact Plan [use standard brand format and logo] Primary Care Physician Checklist for Children

***IMPORTANT** – In order to retain Advantage Level Year-Two benefits in [insert product name, a HEALTHpact Plan], this form must be completed by your adolescent's primary care physician (PCP) for each adolescent (ages 12 to 17 at the time of enrollment) HEALTHpact member and mailed by the member to:

[insert carrier name and address]

no later than 240 days (eight months) after enrollment. If we do not receive of these forms for all 12 to 17 year old family member within 240 days of enrollment, the entire family shall receive Basic level benefits.

1. Member Name: _____
2. Address _____
3. Member Identification Number: _____
4. Date of Birth: _____
5. Date of examination: _____

Body Mass Index

6. Body Mass Index (BMI) calculation
 - a. Weight: _____
 - b. Height: _____
 - c. BMI: _____
7. The member's BMI is above his/her recommended BMI level: Yes No
8. If the member's BMI is above the recommended level, has the physician discussed a weight loss program or goal with the member and the member's parent or guardian? Yes No (leave blank if member's BMI is not above recommended level).
9. Briefly describe the program or goal: _____

10. Additional comments: _____

Smoking

11. Is the member a smoker (has he or she smoked at all within the last 6 months): Yes No
12. If the member is a smoker, has the physician discussed a smoking cessation program or goal with the member and the member's parent or guardian? Yes No (leave blank if member is not a smoker).

13. Briefly describe the program or goal: _____

14. Additional comments: _____

Physician Signature (Required)

The information supplied above is complete and accurate to the best of my knowledge.

Physician Signature: _____ Date: _____

Physician Name (printed): _____

Member Signature (Required) (To be signed by Parent or Guardian)

I have reviewed and discussed the information supplied above with my adolescent's physician and I agree to comply with his/her recommendations. I understand that submission of this PCP Checklist is required in order to continue in the Advantage level of benefits under my HEALTHpact plan.

Member Signature: _____ Date: _____

Additional forms are available at our website, at [insert web address]

**APPENDIX I
PARTICIPATION COMMITMENT FORM**

HEALTHpact Plan [use standard brand format and logo] Participation Commitment Form

***IMPORTANT** – In order to receive Advantage Level benefits in [insert product name, a HEALTHpact Plan], this form must be completed and mailed to:

[insert carrier name and address]

no later than 240 days (eight months) after enrollment. If we do not receive of these forms for all adult family member within 240 days of enrollment, the entire family shall receive Basic level benefits.

1. Member Name: _____
2. Address _____
3. Member Identification Number: _____
4. Date of Birth: _____

To qualify for the Advantage Level Benefits you must confirm your participation in a wellness program(s). Please fill in the appropriate information.

1. Smoker/Tobacco User

Yes

I, _____ (member name), confirm that I am participating in a smoking/tobacco cessation program. Today is _____, 200____, and I understand my participation in the Advantage program is dependent on my engagement in the above mentioned program(s).

Actions Taken:

Signed _____ (member signature)

2. Smoker/Tobacco User

No

I, _____ (member name), confirm that I currently am not a smoker, yet I understand that if I start smoking/using tobacco I will participate in a smoking/tobacco cessation program. Today is _____, 200____, and I understand my participation in the Advantage program is dependent on my compliance with this statement.

Signed _____ (member signature)

3. Weight Management

Yes, my PCP recommended (on my PCP checklist) that I participate in a weight management program.

I, _____ (member name), confirm that I am participating in the applicable weight management program(s) as directed by my PCP. Today is _____, 200____, and I understand my participation in the Advantage program is dependent on my engagement in the above mentioned program.

Actions Taken:

Signed _____ (member signature)

4. Weight Management

No, my PCP did not recommend that I participate in a weight management program.

I, _____ (member name), confirm that I maintain a healthy weight, according to my PCP.

Today is _____, 200____, and I understand my continued participation in the Advantage program is dependent on compliance with this statement.

Signed _____ (member signature)

Additional forms are available at our website,

Appendix J
Rhode Island Small Employer Health Insurance Renewal Explanation Form

**Insurer
Name:
Renewal Date:**

**Group
Name:
Group
Number:**

Factors that Changed Your Rate. In accordance with RI law, the rate change for your small employer plan can only be based on the following factors:

	<u>Product 1</u>	<u>Product 2</u>	- -
A. Approved Average Change in Community Rate Base	x.x%		
B. Actual Experience Adjustment	y.y%		
C. Change in Age, Gender, and Family Composition	z.z%		
D. Change in Relative Value of Benefit Plans	a.a%		
E. Change in Benefits	b.b%		
F. Legally Mandated Changes	c.c%		
G. Total Change in Premium per Subscriber	X.X%		

Explanation of Changes A through G:

- A This change is the average anticipated change in base rates for all groups renewing in 2011. It is based on medical cost, administrative cost, and other estimated inflation (trend) components approved by the Health Insurance Commissioner on [date], and is not specific to your group.
- B This change is based on the insurer's actual claims experience information for all groups renewing in the same month as this group. This more recent information adjusts the inflation (trend) components approved by the Commissioner on [date]. These changes are not specific to your group. While the changes may be positive or negative for any one group, over the course of the year the net effect does not increase average small group premiums in excess of the amounts assumed in line A.
- C This change is the result of any changes in the age, or gender, or family composition of enrolled employees within your specific group. Changes based on age and gender are capped by law at 20% during any renewal policy period. By law, the highest rate cannot exceed 4 times the lowest rate for the same plan of benefits.
- D This change is based on changes in the insurer's rate manual to reflect changes in the relative value of the carrier's benefit plans (e.g. a Preferred Provider Organization Plan vs. a Point of Service Plan vs. a Health Maintenance Organization Plan). These changes are not specific to your group. For all renewing groups, they balance to zero, but some plans may go up and some may go down relative to each other.
- E This is the change due to changes in your benefit plan (higher or lower cost sharing, greater or fewer covered services, etc.) from the plan you purchased last year.
- F This change is due to changes in federal or state law, such as new mandated benefits. For this policy period federal or state law changes include: [identify law change].
- G The total change in premium per subscriber compared to last year's premium is shown on line G, and reflects the

combined effect of the changes in lines A through line F. For the year and all of a carrier's small group business, the net effect of these changes must not exceed this Total Change percentage.

Note on broker or agent commissions: Insurance brokers and agents assist and advise small employers in the selection of health insurance policies, and provide account servicing. Brokers and agents are not employees of any particular health insurance carrier, but may receive commissions from health insurance carriers. In accordance with RI law, these commission payments are charged evenly across all small employers, meaning that small group rates include the average cost of commissions whether your group has a broker or agent or not. \$[pmpm amount] of the monthly premium for each member of your group is used to pay broker or agent commissions.

Questions? Call your agent or broker, [name] at [phone number][if available], or call [name of representative] at [insurer name] at [phone number].



This form was designed on behalf of small employers by the Office of the Health Insurance Commissioner (OHIC) pursuant to RI Gen Law 27-50-12.1. For more information on the rate review process, please contact OHIC at (401) 462-9517; or visit www.ohic.ri.gov/renewalexplanationform.php