

State of Rhode Island and Providence Plantations
DEPARTMENT OF BUSINESS REGULATION
Division of Insurance
233 Richmond Street
Providence, RI 02903

INSURANCE REGULATION ~~LXXXII~~(82)

**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 Director under R.I. Gen. Laws §§ 27-50-11 and 42-14-17.

This Regulation is intended to implement the provisions of Title 27, Chapter 50, "Small Employer Health Insurance Availability Act" (the "Act"), amended by Public Laws Chapters 00-200 and 00-229 and approved by the Governor on July 13, 2000. The purpose of the Act and this Regulation ~~are~~^{is} to provide for the availability of health insurance coverage to small employers, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health benefit plans; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; ~~to define the benefits of a basic health benefit plan to be offered in addition to the standard and economy health benefit plans by all small employer carriers;~~ to direct the basis of market competition away from risk selection and toward the efficient management of

health care; 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. The Act and Regulation are intended 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 which are defined in R.I. Gen. Laws § 27-50-3 shall have the meaning defined therein. In addition, as used in this Regulation:

~~A.~~ ~~“Basic health benefit plan” means the health benefit plan provided under R.I. Gen. Laws § 27-50-10(d) and described in Section 13 of this Regulation.~~

~~B.~~A. “COBRA continuation coverage” means insurance continuation benefits provided under Title X of P.L. 99-272.

~~C.~~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.

~~D.~~C. “Covered employee” means an eligible employee who is or was provided coverage under a group health plan.

~~E.~~D. “Director” means the Director of the Department of Business Regulation.

~~F.~~E. “Individual health insurance policy” means health insurance coverage offered to individuals other than in connection with a group health benefit plan.

~~G.~~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).

~~H.~~G. “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.

H. “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 (18) of the Social Security Act; or
- (5) a dependent child ceasing to be a dependent child under the requirements of the health benefit plan.

I. "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. (1) Except as provided in Paragraph (2) or (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, which:
- (a) meets one or more of the conditions set forth in R.I. Gen. Laws § 27-50-4(a);
 - (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; and
 - (c) is in effect on or after the effective date of the Act.
- (2) The provisions of the Act and this Regulation shall not apply to an Individual health insurance policy delivered or issued for delivery prior to the effective date of the Act.
- (3) The provisions of the Act and this Regulation shall apply to dental, vision or long term care benefits as provided for in 45 CFR 146.145.
- B. (1) 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(II) 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. 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. An Individual health insurance policy shall not be subject to the provisions of the Act and this Regulation solely because the policyholder elects a deduction under Section 162(l) of the Internal Revenue Code.
- E.
 - (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 (50) eligible employees. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than fifty (50) 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)
 - (a) 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.

- (b) A carrier providing coverage to an employer described in Section 3(E)(2)(a) of this Regulation shall, within sixty (60) days of becoming aware that the employer has fifty (50) 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.
- F. (1) (a) 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:
- (i) the majority of eligible employees of such small employer are employed in this state; or
 - (ii) 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.
- (b) In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in Section 3(F)(1)(a) of this Regulation, the provisions of the paragraph 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.
- (2) 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.
- G. 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 for Assumptions of Business from Another Carrier

- A. (1) 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:
- (a) the transaction has been approved by the insurance commissioner of the state of domicile of the assuming carrier;
 - (b) the transaction has been approved by the insurance commissioner of the state of domicile of the ceding carrier; and
 - (c) the transaction otherwise meets the requirements of the Act and these Regulations.

- (2) 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 Director at least sixty (60) days prior to the date of the proposed assumption. The Director may approve the transaction if the Director 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 Director shall not approve the transaction until at least thirty (30) after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Director may approve the transaction as soon as the Director deems appropriate after the filing.
 - (3)
 - (a) The filing required under (2) above shall:
 - (i) describe whether the health benefit plans being assumed are currently available for purchase by small employers;
 - (ii) describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed;
 - (iii) describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed;
 - (iv) 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
 - (v) include any other information required by the Director.
 - (b) A small employer carrier required to make a filing under Section 4(A)(2) of this Regulation 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 Section 4(A)(2) of this Regulation and shall include at least the information specified in Section 4(A)(3)(a) for the small employer health benefit plans in that state.
 - (4) 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 it has provided a notice to the Director at least sixty (60) days prior to the date of the proposed assumption that contains the information specified in Section 4(A)(3) for the health benefit plans covering small employers in this state.
- B. (1) 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.

- (2) 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
- C. 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.
- D. 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 **Restrictions Relating to Premium Rates**

- A. (1) A small employer carrier shall develop a rate manual based on an adjusted community rate that may vary the adjusted community rate only for the following case characteristics:
- (a) age;
 - (b) gender;
 - (c) family composition; and
 - (d) until October 1, 200~~2~~⁴, health status, provided that as of June 1, 2000 the carrier varied rates by health status and provided further such carrier (i) varies the adjusted community rate by health status only as provided in R.I. Gen. Laws § 27-50-5(~~Aa~~), (ii) such variation does not result in rates more than 10% higher or lower than the rates without consideration of health status, and (iii) the adjustments are to be applied uniformly to all small employers covered by the carrier.
- (2) 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.

- (3) 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 Director upon request. The small employer carrier is not required to file such information with the Director for approval prior to use.
 - (4) Except as provided in R.I. Gen. Laws § 27-50-5(a)(6), 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.
- B.
- (1) The rate manual, developed pursuant to Section 5(A) above, shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan.
 - (2) 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.

~~(3) With respect to renewals prior to September 30, 2002, in accordance with R.I. Gen. Laws § 27-50-5(a)(6), a small employer carrier shall make two (2) calculations of premium rates pursuant to (a) and (b) below, with the premium charged to a small employer being the lesser of the two (2) premiums resulting from said calculations with respect to the specific employer:~~

~~(a) A carrier shall make the first calculation in accordance with the standards set forth in the Act, except those in R.I. Gen. Laws § 27-50-5(a)(6) and Section 5(A)(4) of this Regulation.~~

~~(b) The second calculation shall be made in accordance with R.I. Gen. Laws § 27-50-5(a)(6). This calculation shall be based on the premium rate charged by the carrier to the small employer during the prior rating period and shall include the following factors, which may be applied either by addition or by multiplication, utilizing accepted actuarial methods applied in a uniform and nondiscriminatory manner to all small employers covered by the carrier:~~

~~(i) cost and utilization trends appropriate to the carrier's Rhode Island small employer business, except that any adjustments to recognize differences in benefits shall be based solely on the reasonable and objective differences in the design of the health benefits plans and~~

~~shall not be based in any manner on the actual or expected health status or claims of the small employer groups that choose or are expected to choose a particular health benefit plan;~~

~~(ii) premium changes due to changes in the size, age, gender or family composition of the small employer, calculated according to the rate manual used to determine that employer's rate during the prior rating period;~~

~~(iii) ten percent (10%); and~~

~~(iv) any change in the actuarial value of the small employer's benefits, calculated according to the rating methods used during the prior rate period.~~

(43) (a) Except as provided in Section 5(A)(43)(b) of this Regulation, 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.

(b) 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 (\$5.00) per month per employee and is applied in a uniform manner to each health benefit plan.

(54) A small employer carrier shall allocate administrative expenses to the ~~basic~~, standard and economy health benefit plans on a no less favorable basis than expenses are allocated to other health benefit plans. The rate manual developed pursuant to Section 5(A) of this Regulation shall describe the method of allocating administrative expenses to the health benefit plans for which the manual was developed.

(65) The rate manual developed pursuant to Section 5(A) shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual.

(76) The rate manual and rating practices of a small employer carrier shall comply with all guidelines issued by the Director.

C. If an employer does not meet the definition of a "small employer" under R.I. Gen. Laws § 27-50-3(LL), 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 5 shall not apply.

Section 6 Requirement to Insure Entire Group

A. (1) 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 Section 6(A)(2) of this Regulation, the small employer carrier shall provide the same health benefit plan to each such employee and dependent.

- (2) 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.
- B.
- (1) A small employer carrier shall require each small employer that 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(n). 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.
 - (2)
 - (a) 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.
 - (b) 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.
 - (c) The waiver form shall:
 - (i) require that the reason for declining coverage be stated on the form;
 - (ii) include a written warning of the penalties imposed on late enrollees; and
 - (iii) 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).
 - (d) 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.
 - (e) Waivers and certifications of refusal to sign waivers shall be maintained by the small employer carrier for a period of six (6) years.

- (3) (a) A small employer carrier shall not issue coverage to a small employer that refuses to provide the list of eligible employees and dependants required under Section 6(B) or a waiver required under Section 6(B)(2) of this Regulation.

Section 7 Application to Reenter State

- A. 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 Director seeking to be reinstated as a small employer carrier and the petition has been approved by the Director. In reviewing a petition to reinstate, the Director may ask for such information and assurances as the Director deems reasonable and appropriate.
- B. In the case of a small employer carrier doing business in only one (1) 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 (5) 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 Director. In considering whether to grant approval to offer health benefit plans, the Director may ask for such information and assurances as the Director deems reasonable and appropriate.

Section 8 Certification and Disclosure of Prior Creditable Coverage

- A. (1) (a) Small employer carriers shall provide written certification of creditable coverage, as that term is defined in R.I. Gen. Laws § 27-50-3(j), 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) (i) A small employer carrier is not required to provide information regarding health benefit plan coverage provided to an individual by another person.

- (ii)
 - (I) 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.
 - (II) The provision of the information pursuant to (I) above to the carrier shall satisfy the entity's obligation to provide an automatic certificate pursuant to this Section and Section 8(B) below.
 - (III) The entity providing the information pursuant to (I) above shall cooperate with the carrier in responding to any request made under Section 8(F)(2) below.
 - (IV) 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 Section 8(A)(2) or (3) below.
 - (V) 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)
 - (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)
 - (i) A small employer carrier satisfies the requirements of Section 8(2)(a)(i) above 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.

- (ii) (I) A small employer carrier satisfies Section 8(2)(a)(ii) above if the carrier provides the certification within a reasonable time after coverage under the group health plan ceases.
 - (II) 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 Section 8(2)(a)(ii) above 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) (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 (a) above 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 (a) above to an individual regardless of whether the individual previously has received a certificate under Section 8(2)(a)(i) above.
 - (4) (a) (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 (24) 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. (1) (a) Except as provided in (b) below, a certificate provided under Section (8)(A)(1) shall be in writing.

- (b) A written certificate is not required to be provided pursuant to Section (8)(A)(2), (3), or (4) 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 Section (8)(A)(2), (3), or (4).

- (2) A certificate provided pursuant to this subsection 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 (d) above;
 - (f) either:
 - (i) a statement that the individual has at least eighteen (18) 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) (a) If an automatic certificate is provided pursuant to Section 8(A)(2) or (3), the period included on the certificate shall be the last period of continuous coverage ending on the date the coverage ceased.
 - (b) (i) For a certificate requested pursuant to Section 8(A)(4) above, the certificate must be provided for each period of continuous coverage ending within the twenty-four (24) month period ending on the date of the request or continuing on the date of the request.
 - (ii) A separate certificate may be provided for each period of continuous coverage.
 - (4) (a) A certificate may provide the information required pursuant to Section 8(B)(2) above with respect to both a participant and the participant's dependents if the information is identical for each individual.
 - (b) If the information required pursuant to (2) above 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.
 - (5) Appendix B contains a model certificate that a small employer carrier may use to satisfy the requirements of Section 8(B)(2).
 - (6) (a) (i) Except as provided in (ii) below, 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(u)(2), (3), (4) and (5).
 - (ii) If the excepted benefits are being provided concurrently with other creditable coverage, a small employer carrier may be required to disclose information concerning the benefits under Section 8(F) below.
 - (b) A small employer carrier is not required to include in a certificate information regarding coverage that specifies categories of benefits as described in R.I. Gen. Laws § 27-50-7(c)(3).
- C. (1) Small employer carriers may provide a certificate required to be provided pursuant to this Section by first-class mail.
- (2) (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)
 - (a) If a small employer carrier is required to provide a certificate automatically to an individual pursuant to Section 8(A)(2) or (3) above, 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 Section 8(A)(4) above 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.
 - (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 Section 8(A)(2) or (3), 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)
 - (a) 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 Section 8(G)(5) below for demonstrating dependent status.
 - (b) In addition to (a) above, an individual may, if necessary, use the procedures described in Section 8(G)(5) below to demonstrate that a child was enrolled within thirty (30) days of birth, adoption or placement for adoption.
- E.
 - (1) 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.
 - (2) (1) above applies to coverage provided in connection with:
 - (a) Creditable coverage described in R.I. Gen. Laws § 27-50-3(j)(1)(b) through (j); and

- (b) Coverage subject to Section 2721(b)(1)(B) of the Public Health Service Act (PHSA).
- F.
 - (1) 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 in (2) below.
 - (2)
 - (a) The information required to be provided by the entity pursuant to Paragraph (1) above shall 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.
 - (b) For the purpose of (a) above , 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.
 - (3) The entity providing the information pursuant to this Section may charge the small employer carrier requesting the information for the reasonable cost of providing the information.
- G.
 - (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) (1) above 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 coverage is for a period prior to July 1, 1996;
 - (d) 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

- (e) the individual lost a certificate that the individual had previously received and is unable to obtain another certificate.
- (3)
- (a) 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.
 - (b) A small employer carrier shall treat the individual as having provided a certificate pursuant to this Section if the individual:
 - (i) attests to the period of creditable coverage;
 - (ii) presents relevant corroborating evidence of some creditable coverage during the period; and
 - (iii) cooperates with the carrier's efforts to verify the individual's coverage.
 - (c) 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.
 - (d) For the purpose of Section 8(G)(3)(b)(iii) and (c) above, "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.
- (4)
- (a) Documents that may establish creditable coverage and waiting or affiliation periods in the absence of a certificate include:
 - (i) explanation of benefit (EOB) or other correspondence from a carrier indicating health benefit plan coverage;
 - (ii) pay stubs showing a payroll deduction for health benefit plan coverage;
 - (iii) a health insurance identification card;
 - (iv) a certificate of coverage under a group health plan;
 - (v) records from health care providers, indicating health benefit plan coverage;

- (vi) third party statements verifying periods of health benefit plan coverage; and
 - (vii) any other relevant documents that evidence periods of health benefit plan coverage.
 - (b) In addition to (a) above of this paragraph, 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.
 - (5) 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.
 - (6) 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 Section 8(F) relating to determining creditable coverage under the alternative method.
- H.
- (1)
 - (a) 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 (2) below.
 - (b) 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.
 - (2)
 - (a) 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.
 - (b) A small employer carrier shall include in the notice provided under (a) above 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.

- (3) Nothing in this subsection or Section 8(G) 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:
 - (i) the carrier provides a notice of reconsideration to the individual; and
 - (ii) 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. A restrictive rider, endorsement or other provision that would violate the provisions of R.I. Gen. Laws § 27-50-7(d)(10)(iii) and that was in force on the effective date of this Regulation may not remain in force beyond the first anniversary date of the health benefit plan subject to the restrictive provision that follows the effective date of this Regulation. A small employer carrier shall provide written notice to those small employers whose coverage will be changed pursuant to this subsection at least thirty (30) days prior to the required change to the health benefit plan.
- B. Except as permitted in R.I. Gen. Laws § 27-50-7(d)(2), a small employer carrier shall not modify or restrict a ~~basic~~, standard or economy health benefit plan in any manner for the purposes of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.
- C. 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. (1) A small employer carrier shall actively market each of its health benefit plans to small employers in this state. A small employer carrier may not suspend the marketing or issuance of the ~~basic~~, standard or economy health benefit plans unless the carrier has good cause and has received the prior approval of the Director.
- (2) In marketing the ~~basic~~, standard and economy health benefit plans to small employers, a small employer carrier shall use at least the same sources and meth-

ods of distribution that it uses to market other health benefit plans to small employers. 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 ~~basic~~, standard and economy health benefit plans.

- B. (1) (a) A small employer carrier shall actively offer all health benefit plans it actively markets in this state, including at least the ~~basic~~, standard and economy health benefit plans, to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier.
- (b) The offer may be provided directly to the small employer or delivered through a producer.
- (2) The offer shall be in writing and shall include at least the following information:
- (a) a general description of the benefits contained in the ~~basic~~, standard and economy health benefit plans and any other health benefit plan being offered to the small employer; and
- (b) information describing how the small employer may enroll in the plans.
- (3) (a) A small employer carrier shall provide a price quote to a small employer directly or through an authorized producer within ten (10) 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 (5) working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.
- (b) A small employer carrier may not apply more stringent or detailed requirements related to the application process for the ~~basic~~, standard and economy health benefit plans than are applied for other health benefit plans offered by the carrier.
- (4) 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.
- (5) 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.

C. 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. 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.

- D. 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.
- E. 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.
- F.
 - (1) 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.
 - (2) Carriers shall elicit the following information from applicants for such plans at the time of application:
 - (a) 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
 - (b) 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.
 - (3) If a small employer carrier fails to comply with Section 10(F)(2) of this Regulation, 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 Section 10(F)(2) of this Regulation.
- G.
 - (1) A small employer carrier shall file annually the following information with the Director related to health benefit plans issued by the small employer carrier to small employers in this state:
 - (a) the number of small employers that were issued health benefit plans in the previous calendar year (separated as to newly issued plans and renewals and separated as to those that were accepted after medical underwriting and those to which no medical underwriting was applied);
 - (b) the number of small employers that were issued ~~basic health benefit plan~~, the standard health benefit plan and the economy health benefit plan in the previous calendar year (separated as to newly issued plans and renewals);

- (c) the number of small employer health benefit plans in force in each county (or by zip code) of the state as of December 31 of the previous calendar year;
 - (d) the number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;
 - (e) the number of small employer health benefit plans that were terminated or nonrenewed for reasons other than nonpayment of premium by the carrier in the previous calendar year; and
 - (f) the number of small employer health benefit plans that were issued to small employers that were uninsured for at least the three (3) months prior to issue.
- (2) The information described in Section 10(G)(1) of this Regulation shall be filed no later than March 15 of each year.

Section 11 Status of Carriers as Small Employer Carriers

- A. ~~Within thirty (30) days after the effective date of this Regulation~~No later than December 6, 2001, each carrier providing health benefit plans in this state shall make a filing with the Director indicating whether the carrier intends to operate as a small employer carrier in this state under the terms of this Regulation.
- B. Subject to Section 11(C) of this Regulation, 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 Section 11(A) of this Regulation indicates that the carrier intends to operate as a small employer carrier in this state.
- C. (1) If the filing made pursuant Section 11(A) 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:
- (a) 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;
 - (b) the carrier provides coverage to each new entrant to a health benefit plan previously issued to a small employer by the carrier; and
 - (c) 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.

(2) For the purpose of Section 11(C)(1)(b), the provisions of the Act and this Regulation shall apply to the coverage issued to new entrants.

D. If the filing made pursuant to Section 11(A) of this Regulation 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 Section 11(C) of this Regulation, for a period of five (5) years from the date of the filing. Upon a written request from a carrier, the Director may reduce said period provided for in the previous sentence if the Director 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 Restoration of Coverage

A. (1) Except as provided in Section 12(A)(2) of this Regulation, a small employer carrier shall, as a condition of continuing to transact business in this state with small employers, offer to provide a health benefit plan as described in Section 12(C) of this Regulation to any small employer whose coverage was terminated or not renewed by such small employer carrier after January 1, 1992.

(2) The offer required under Section 12(A)(1) of this Regulation shall not be required with respect to a health benefit plan that was not renewed if:

(a) the health benefit plans was not renewed for reasons permitted in R.I. Gen. Laws § 27-50-6(a), or

(b) The nonrenewal was a result of the small employer voluntarily electing coverage under a different health benefit plan.

B. The offer made under Section 12(A) of this Regulation shall occur not later than thirty (30) days after a carrier indicates its intention to operate as a small employer carrier in this state pursuant to Section 11(A) of this Regulation. A small employer shall be given at least sixty (60) days to accept an offer made pursuant to Section 12(A) of this Regulation.

C. (1) A health benefit plan provided to a terminated small employer pursuant to Section 12(A) of this Regulation shall meet all of the conditions in (2) through (6) below.

(2) The health benefit plan shall contain benefits that are identical to the benefits in the health benefit plan that was terminated or nonrenewed.

(3) The health benefit plan shall not be subject to any waiting periods, including exclusion periods for preexisting conditions or other limitations on coverage that exceed those contained in the health benefit plan that was terminated or nonrenewed. In applying such exclusions or limitations, the health benefit plan

shall be treated as if it were continuously in force from the date it was originally issued to the date that it is restored pursuant to this Section and R.I. Gen. Laws § 27-50-15 .

- (4) The health benefit plan shall not be subject to any provision that restricts or excludes coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.
- (5) The health benefit plan shall provide coverage to all employees who are eligible employees as of the date the plan is restored. The carrier shall offer coverage to each dependent of such eligible employees.
- (6) The premium rate for the health benefit plan shall be no more than the premium rate charged to the small employer on the date the health benefit plan was terminated or nonrenewed; provided that, if the number or case characteristics of the eligible employees, or their dependents, of the small employer has changed between the date the health benefit plan was terminated or nonrenewed and the date that it is restored, the carrier may adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may further be adjusted to reflect the lowest such increase given to a similar group.

~~*Section 13 ——— Basic Health Benefit Plan*~~

~~A small employer carrier shall develop and actively market within this state at least one (1) health benefit plan that meets the requirements of a basic health benefit plan, as specified in this Section.~~

~~A. ——— A health benefit plan approved by the Director as meeting the requirements of this Section may be designated as the basic health benefit plan by the small employer carrier and marketed as such to any small employer in this state.~~

~~B. ——— (1) ——— A basic health benefit plan shall include coverage of:~~

~~(a) ——— Physician Office Outpatient Services Requiring Co-Payment. ——— The following visits to the office of a physician or other qualified health care practitioner participating in the health benefit plan shall be covered and at a maximum co-payment of fifteen dollars (\$15) per visit:~~

~~(i) primary care physician office visits;~~

~~(ii) specialty physician office visits;~~

~~(iii) physical examination visits;~~

~~(iv) eye examination service visits. Covered visits shall not be limited to less than once every two years;~~

~~(v)allergy or dermatology service visits;~~

~~(vi)well baby care;~~

~~(vii)chiropractic services. Covered visits shall not be limited to less than six (6) per calendar year.~~

~~(viii)podiatric services; and~~

~~(ix)speech, occupational, physical, cardiac/pulmonary therapy or rehabilitation.~~

~~(b) Office and Other Outpatient Services Not Requiring Co-Payment. Visits to the offices of physicians or other qualified health care practitioners or facilities for the following services shall be covered and shall have no co-payment:~~

~~(i)pregnancy care, including pre-natal and post-natal care; and~~

~~(ii)diagnostic x-rays, laboratory tests and therapeutic treatment.~~

~~(2) Emergency, Emergent and Urgent Care. The following services shall be covered at the co-payment rate indicated, or for a lesser amount. The health benefit plan may expand the scope or duration of services, but shall not increase co-payment levels above the maximum level specified.~~

~~(a)Emergency Room Care, fifty dollar (\$50) maximum co-payment per visit. Co-payment shall be waived if admission is required.~~

~~(b)Ambulance Services, twenty five dollar (\$25) maximum co-payment per occurrence. Air Ambulance and municipal rescue unit services may be covered at the discretion of the carrier. Air ambulance services may require pre-authorization by the health benefit plan.~~

~~(c)Urgent Care Centers, maximum co-payment of twenty five dollars (\$25) per occurrence.~~

~~(3) Inpatient Services, excluding mental health and substance abuse. The following inpatient services shall be covered and there shall be no co-payment:~~

~~(a)hospital services, unlimited days in a semi-private room;~~

~~(b)inpatient physician services;~~

~~(c)surgical and related services; and~~

~~(d) organ and tissue transplants.~~

~~(4) Mental Health Services. The following inpatient and outpatient mental health services shall be covered for at least the duration indicated and for a charge not to exceed the maximum co-payment under the conditions specified below:~~

~~(a) inpatient, two hundred fifty dollar (\$250) maximum co-payment per admission. Covered stay shall be no less than forty five (45) days per calendar year. Pre-authorization by health benefit plan may be required~~

~~(b) outpatient, fifteen dollar (\$15) maximum co-payment per visit. Covered visits shall not be limited to less than twenty (20) visits per calendar year.~~

~~(5) Substance Abuse Services. Substance abuse evaluation, treatment and rehabilitative services shall be available in accordance with the following:~~

~~(a) inpatient~~

~~(i) detoxification, no co-payment. Covered services shall not be limited to less than three (3) admissions per year or twenty one (21) days per calendar year, whichever comes first.~~

~~(ii) rehabilitation, two hundred fifty dollar (\$250) maximum co-payment per admission. Covered services shall not be limited to less than thirty (30) days per calendar year, or less than ninety (90) days over an individual's lifetime.~~

~~(b) Outpatient services, maximum of fifteen dollar (\$15) co-payment per visit. Coverage shall not be limited to less than thirty (30) hours per individual or less than twenty (20) hours per family.~~

~~(6) Prescription Drugs. A basic health benefit plan shall cover a thirty two (32) day minimum supply of all of the following brands of prescription drugs at a co-payment level not to exceed the amount specified, each time a prescription is filled or refilled:~~

~~(a) non-formulary brand, maximum of thirty dollar (\$30) co-payment per prescription;~~

~~(b) formulary brand, maximum of twenty dollar (\$20) co-payment per prescription; and~~

~~(c) generic brand, maximum of ten dollar (\$10) co-payment per prescription.~~

~~(7) Ancillary Health Care Services. Other health care services that shall be covered by a basic health benefit plan include, but are not limited to, the following:~~

~~(a) Home Care. There shall be no co-payment for home care services when ordered by a physician and preauthorized by the carrier as part of a treatment plan.~~

~~(b) Hospice Care, maximum of two hundred fifty dollar (\$250) co-payment per admission when ordered by a physician and pre-authorized by the carrier. Hospice care shall be covered for at least two hundred ten (210) days in the lifetime of an individual covered by a basic health benefit plan.~~

~~(c) Home Infusion Therapy. There shall be no co-payment when ordered by a physician and pre-authorized by the carrier.~~

~~(d) Durable Medical Equipment, including prosthetic devices. Cost-sharing shall not exceed twenty dollars (\$20) per item or twenty percent (20%) of the cost. Preauthorization may be required by the carrier.~~

~~(e) Emergency Dental Care. There shall be no co-payment when the services are necessary to control pain, bleeding or infection or are provided in conjunction with the initial evaluation and treatment of accidental injury.~~

~~(f) Skilled Nursing Facilities. There shall be no co-payment when preauthorized by the carrier as an alternative to inpatient hospital care.~~

~~(8) Mandated Under Rhode Island Law. Any services not specified in this Section that a carrier is required to cover by State law shall be a covered service under the basic health benefit plan. Such services shall be covered for the scope and duration specified and at the co-payment or cost-sharing level required by law.~~

~~C. (1) The following cost-containment mechanisms may be included in a basic health benefit plan:~~

~~(a) Provider Networks. A basic health benefit plan may utilize a contracted provider. A basic health benefit plan may offer optional coverage of non-network provider services providing all other requirements of this Regulation.~~

~~(b) Primary Care Provider Model. A basic health benefit plan may organize service delivery using a primary care physician model. The chief responsibility of the primary care physician shall be to provide basic medical services and as appropriate make referrals for specialty and ancillary medical services.~~

~~(i) For the purposes of this Section, a primary care provider is any licensed allopathic or osteopathic physician qualified to practice in the areas of internal medicine, pediatrics, family medicine, obstetrics and gynecology, or adult medicine. In certain circumstances, licensed physician assistants and advanced practice nurses may serve in the role of a primary care provider.~~

~~(ii) The primary care provider may be required to pre-approve utilization of all health care services and otherwise serve in the capacity of gatekeeper.~~

~~(c) Pre-authorization of Services. A basic health benefit plan may require pre-authorization for any health care.~~

~~(d) Alternatives to Inpatient Care. A basic health benefit plan may provide coverage for alternative forms of care that are less costly, but no less efficacious than inpatient care.~~

~~(e) Pre-admission Certification. Except in cases of an emergency, a basic health benefit plan may require that patients obtain pre-admission certification for inpatient hospital services.~~

~~(f) Mandatory Second Opinion. A basic health benefit plan may mandate that a patient obtain a second opinion before an elective surgery.~~

~~(g) Utilization Review and Management. To ensure the responsible use of services, a basic health benefit plan may institute procedures for concurrent utilization review and management.~~

~~(h) Discharge Planning. A basic health benefit plan may provide discharge planning for hospital care.~~

~~D. Provider Contracting~~

~~Nothing in this Section shall be construed to limit or otherwise restrict the ability of a small employer carrier to establish contractual arrangements with certain health care providers, practitioners, and facilities.~~

~~**Section 143** **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 154** **Effective Date**~~

~~This Regulation shall be effective on November 6, 2001 twenty (20) days after filing with the Secretary of State.~~

~~As provided in RI Gen. Laws, §§ 27-50-7(b)(1) and 27-50-10(d), all carriers shall actively offer at least one Basic Plan as provided in Section 13 as a condition of transacting small employer business in this state on and after January 1, 2002.~~

Effective Date: March 30, 1994
Amended: August 2, 2001
November 6, 2001
September 2003

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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: _____
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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.