



Office of Health Insurance Commissioner
1511 Pontiac Avenue
Cranston, Rhode Island 02920

Health Insurance Commissioner Bulletin Number 2018-5

Forms for compliance with Small Employer Health Insurance Availability

The following are the Appendixes referenced in 230-RICR-20-30-10 - Small Employer Health Insurance Availability.

- Appendix A – Model Description of Special Enrollment Rights
- Appendix B – Certificate of Group Health Plan Coverage
- Appendix C – Model Instructions for Year-One Advantage-Level Benefits
- Appendix D – Model HEALTHpact Pledge Form
- Appendix E – Model Instructions for Year-Two Advantage-Level Benefits
- Appendix G – Primary Care Physician Checklist for Adults
- Appendix H – Primary Care Physician Checklist for Adolescents
- Appendix I – Participation Commitment Form
- Appendix J – Rhode Island Small Employer Health Insurance Renewal Explanation Form

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 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.