State of Rhode Island
DEPARTMENT OF BUSINESS REGULATION
1511 Pontiac Avenue, Bldg. 69-2
Cranston, Rhode Island 02920

Insurance Division

Non-OHIC Health* Filing Guidelines

Policy Form and Rate Filing Requirements and Regulatory Compliance

*- Including: Disability Income, Hospital Confinement, Accidental Death and Dismemberment, Specified Disease, Cancer Indemnity, Critical Illness, Blanket Accident & Sickness, Health Related Travel, and any other Limited Benefit Policies

A. Department Contact Information for all the above lines of business (LOB)

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Governing form filing statutes/regulations

- Accident and Sickness Insurance Policies: RI General Laws § 27-18
- Limited Lines Travel Insurance Act: RI General Laws § 27-79
- Minimum Standards for Health Benefit Plans: 230-RICR-20-30-1
- Health Insurance Reserves: 230-RICR-20-30-3

Other relevant statutes/regulations

- Unfair Life, Accident, and Health Claims Settlement Practices: 230-RICR-20-40-1
- Unfair Competition and Practices: RI General Laws § 27-29
- Civil Unions: 230-RICR-20-60-5
- Privacy of Consumer Information: 230-RICR-20-60-7

B. Filing Requirements

1. All filings along with applicable fees must be submitted via SERFF. Please see Insurance

Bulletins 2007-3 and 2002-13. Filing fees are calculated on a retaliatory basis pursuant to RI General Laws § 42-14-18 and § 27-2-17. Filings fees are not required for withdrawal of filings (without replacements). **All other filings require a filing fee.**

2. Form/Rate Filings: All health benefit contract forms and rates must be filed for review and approval pursuant to RI General Laws § 27-18-8 and 230-RICR-20-30-1 (part 1.11). Additionally, each rate filing must include a certification signed by a qualified actuary stating that to the best of the actuary's knowledge and judgement, the entire rate filing is in compliance with applicable laws and that the benefits offered or proposed to be offered are reasonable in relation to the premium to be charged.

3. Health Filings: Medical Stop-Loss, Dental and Vision forms and rates must be filed with the Office of the Health Insurance Commissioner (OHIC), separately from life, accident, critical illness, disability, accident, death and dismemberment insurance products or other limited benefit insurance policies. Applications or other dual-usage forms that are subject to both DBR's and OHIC's jurisdiction may be filed with both agencies, accompanied by a note acknowledging that the relevant OHIC language has also been filed separately with OHIC for approval.

4. For revisions to existing form, rule and rate filings, insurers are required to provide a side-by-side comparison of the revisions. Such revisions must be identified by underlining or highlighting (additions) and strike-through (deletions). In addition, insurers must provide an explanation as to the impact such revisions have on existing coverage, i.e., broadening or restricting coverage, etc.

5. Any filing of new forms to be used with previously-approved forms must include a list of such forms as Supporting Documentation. Approval dates and SERFF Tracking Numbers, if available, must be included on that document as well.

6. Note: any extension of previously-approved forms in a manner other than what was originally filed must be submitted to the Department for review and approval. An appropriate filing fee must be submitted with such a filing.

7. Statement of Variability: Variable text is permitted using brackets on a filed form, providing a corresponding Statement of Variability is submitted with the form. Numeric values must include ranges of what the item could be for future issues. Each variable must clearly indicate when language will/will not appear on the filed form, and alternate text is permitted only if the exact language is included on the Statement of Variability.

8. Filings are public upon receipt. For confidentiality requests, the insurer must provide a specific statutory basis as well as a full description of how the request for confidentiality falls under RI General Laws § 38-2-2. The Department may override a request if the information is deemed not to be appropriate to be held confidential. An insurer may not mark an entire filing as confidential. The insurer must clearly identify portions deemed confidential, cite relevant statute and support for exemption under RI General Laws § 38-2-2(4), and properly segregate such from the remaining public portion of the filing.

9. Typographical errors: The Department **DOES NOT ALLOW** changes to previously approved

forms due to typographical errors without first notifying the Department. If the effective date for the original filing has not yet occurred, the insurer may request to have the Department reopen the original filing to upload the corrected form(s). Otherwise, if the effective date has passed, the insurer must submit a new filing to the Department along with the appropriate filing fee(s).

C. Information Filings – the "Requested Filing Mode" must be marked as "Informational". Informational filings should only be submitted for the following:

1. Certification Filings: Carriers submitting certifications subject to RI General Laws § 27-50-3(t)(6) should file them as informational. The correct TOI to use is "H21 Health - Other". A filing fee of $25 is required, if the retaliatory fee is not greater than the RI fee.

2. Use of Electronic Applications: The Department will **no longer** accept requests to use previously approved paper applications electronically as informational filings. Please submit these filings for "Review & Approval." In addition to the previously-approved forms list, the Department also requires the following information:

   - Detailed description of the application process
   - A statement from the filer that the electronic version matches the paper application, or explanation if there are any variations
   - Explanation of whether or not the application will be attached to the contract, and by extension whether or not the representations made by the consumer can be used to contest or void the contract

Please note: material changes to a Statement of Variability may **NOT** be filed as informational, including but not limited to changes to fee ranges, language added for a variable on a previously-approved form, changes to previously filed actuarial memoranda, etc. These changes must be filed for approval with an appropriate filing fee(s).

D. Prohibitions and/or specific statutory mandates should be considered when preparing filings[1]

All accident and sickness insurance policies issued in Rhode Island must have the following provisions, pursuant to RI General Laws § 27-18-3:

1. Entire Contract: a provision stating that the policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance, no change is valid until it is approved by an executive officer of the insurer and attached to the policy, and no agent has authority to change a policy or to waive any of its provisions.

2. Time Limit of Certain Defenses: No misstatements made by the applicant in the application may be used to void the policy or to deny a claim for loss incurred or disability after three (3)

[1] The cited statutes and regulations in this section are a compilation of objections the Department frequently sends back to filers and can amended to include other common filing errors identified in the future. However, filer should not view this as an exhaustive list of all potential objections the Department can submit. If a filer has a specific question, please call or email the Department contact listed under Section A.

years from the date of issue, except for fraudulent misstatements.

3. Grace Period: a provision granting a grace period must be granted for payment of each premium falling due after the first premium, during which the grace period will continue in force. The grace period must not be less than seven (7) days for weekly premium policies, ten (10) for monthly premium policies, and thirty-one (31) for all other policies.

4. Reinstatement: a provision that states a policy must be reinstated if the insurer accepts a renewal premium not paid within the time granted to the insured without requiring an application for reinstatement. If the insurer requires an application for reinstatement, issues conditional receipt for the premium tendered, and the policy is reinstated upon approval of the application, approval must be granted within forty-five (45) days following conditional receipt of the premium, unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy must cover only loss resulting from an accidental injury as may be sustained after the date of reinstatement and loss due to a sickness as may begin more than ten (10) days after this date.

5. Notice of Claim: a provision that states written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon after this as reasonably possible.

6. Claim Forms: a provision that states an insurer must provide a claimant with any forms necessary for filing proof of loss upon notification of a claim. Forms must be furnished to claimant within fifteen (15) days of notification.

7. Proofs of Loss: a provision that states written proof of loss must be furnished to the insurer within ninety (90) days after the date of loss. Failure to furnish proof within the time required does not invalidate nor reduce any claim if it was not reasonably possible to give proof within this time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is required.

8. Time of Payment of Claims: a provision that states indemnities payable under the policy for any loss other than loss for which the policy provides any periodic payment will be paid immediately upon receipt of due written proof of loss.

9. Payment of Claims: a provision that states indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting the payment which may be prescribed in the policy and effective at the time of payment.

10. Physical Examinations and Autopsy: a provision that states that an insurer may have the right to examine the insured, at its own expense, when and as often as it may be reasonably required during the pendency of a claim under the policy and to make an autopsy in case of death where law does not forbid it.

11. Legal Actions: a provision that states no action at law or in equity may be brought to recover on a policy prior to sixty (60) days after written proof of loss, and no action may be brought after the expiration of three (3) years after the time written proof of loss is required to be

furnished.

12. Change of Beneficiary: a provision allowing the insured the right to change his/her beneficiary without the consent of the beneficiary, unless the insured makes an irrevocable beneficiary designation.

13. Definitions: provisions that include the terms defined in RI General Laws § 27-18-3(a)(13).

14. Statements in the Application: Pursuant to 230-RICR-20-30-1.6, applications for any health benefit contract where an applicant's physical condition is considered must include a statement signed by the applicant that states the following statement, or language substantially similar (subject to the Department's approval): "I hereby certify that I have read the above statements or that they have been read to me and that the above statements are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk."

15. Permitted exclusions: Pursuant to 230-RICR-20-30-1.7.2(D), no contract may exclude coverage by type of illness, accident, treatment, or medical condition, except as follows:

    - Pre-existing conditions or diseases, except for congenital anomalies of a covered dependent child;
    - Mental or emotional disorders, alcoholism and drug addiction;
    - Pregnancy, except for complications of pregnancy;
    - Illness, treatment or medical condition arising out of:
        - War or act of war (declared or undeclared); participation in a felony, riot, or insurrection; service in the armed forces;
        - Suicide, attempted suicide or intentionally self-inflicted injury;
        - Aviation;
        - Interscholastic sports (short-term non-renewable contracts only)
    - Cosmetic surgery;
    - Foot care;
    - Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;
    - Treatment provided in a government hospital, however, contracts providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the Federal Government; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workmen's compensation, employers liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institution; services performed by a member of the covered person's immediate family and services for which

no charge is normally made in the absence of insurance.;
- Dental care or treatment;
- Eye glasses, hearing aids, and examination for the prescription or fitting thereof;
- Rest cures, custodial care, transportation, and routine physical examinations;
- Territorial limitations.

16. Outline of Coverage: A health benefit contract subject to 230-RICR-20-30-1 must include an Outline of Coverage. Requirements differ depending on the LOB submitted in the filing; see Part 1.7.4 (C) through (H) for further explanation as to what must be included in each product's Outline of Coverage.

17. Required Disclosure provision: Every Limited Benefit Policy contract must include a renewal, continuation, or nonrenewal provision pursuant to 230-RICR-20-30-1.7.4(A). General statements such as "SEE SPECIAL RENEWAL PROVISION" are not permitted.

18. Group and Blanket Health Contract Standard Provisions can be found under 230-RICR-20-30-1.8.1. Pertinent contractual provisions include but are not limited to the following:

    i. Grace Period: Group and Blanket Health Benefit insurance policies must contain a provision that the master contract holder is entitled to a grace period of thirty-one (31) days, or at the option of the insurer, one month for the payment of any premium due except the first. This can be found under 230-RICR-20-30-1 1.8.1(A)(6)(a).

    ii. Incontestability: Group and Blanket Health Benefit insurance policies are incontestable after two years from date of issue, except for nonpayment of premium payments. This can be found under 230-RICR-20-30-1.8.1(A)(6).

    iii. Exclusions or limitations: Group and Blanket Health Benefit insurance policies may only exclude or limit coverage to a disease or physical condition for which medical advice or treatment was received for twelve (12) months prior to the effective date of coverage. In no event may such exclusion or limitation apply to loss incurred after the earlier of (a) the end of the continuous period of twelve (12) months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connections with such disease or physical condition and (b) the end of the two (2) year period commencing on the effective date of the person's coverage. This can be found under 230-RICR-20-30-1.8.1(A)(6)(e).

    iv. A provision that all benefits payable under the contract must be paid within 60 days after receipt of proof of loss, subject to 230-RICR-20-30-1.8.1(A)(6)(k)

19. Conversion: Pursuant to 230-RICR-20-30-1.8, a group health benefit contract must contain a provision that allows an employee or member to have a converted contract if the original contract has been terminated for any reason other than discontinuance of the group contract in its entirety and who has been continuously covered under the group contract for at least three months prior to termination. Per 230-RICR-20-30-1.8.3(A), an employee or member eligible to apply for a converted health benefit contract must be given written notice of such within fifteen (15) days prior to the expiration of the thirty-one (31) day conversion period. If the employee or member is not given notice of his/her conversion rights within the fifteen (15) days, the employee or member is entitled to an additional period to apply for a converted contract, either fifteen (15) days after the employee or member has been given notice or ninety (90) days after termination of coverage, whichever is earlier.

20. Fraud Warning: Applications must comply with RI General Laws § 27-54.1-3 and must contain the following statement or a substantially similar statement: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

21. Discretionary Clauses: Discretionary clauses are not permitted in any insurance contracts pursuant to RI General Laws § 27-18-79.

22. Civil unions and same sex marriage: Effective August 1, 2013, "Same Sex Marriage" law took effect in RI, RI General Laws § 15-1-1 *et seq*. Please see 230-RICR-20-60-5 and Insurance Bulletin 2013-2 for filing requirements and coverage standards. Prior to August 1, 2013, Civil Union provisions applied.

E. Rate Filing Requests – Each health benefit rate filing is subject to an actuarial review to determine if the request is justified, and the Department suggests that Companies consider targeting the following loss ratios, broken down by line of business and marketing methods:

- Individual Policies or Group Policies marketed to individual consumers
  - Health Products: 65%
  - Loss of Income or Other (non-Long-Term Care):
    - Non-Cancellable or Guaranteed Renewable: 50%
    - Conditionally Renewable: 55%
    - Optionally Renewable: 60%
- Group Policies
  - Health Products: 60%
  - Loss of Income and Other: 50%

F. General Information

- Filings of Previously Approved Forms due to change in name, officer, address and/or merger with licensed insurers Insurance Bulletin 2005-7. For change in "logo" only,

insurer is required to submit 1 sample policy cover with new logo along with a statement that the logo will be used on all policy forms. Insurer does not need to list all forms it will apply the new logo to, rather a statement that the logo will be used on all forms on a go forward basis. The filing should be submitted in SERFF along with the filing fee.

- Forms submitted for approval due to an assumption or transfer of business must be submitted in compliance with the Assumption Reinsurance Act under RIGL §27-53.1, if applicable. This act mandates the filing requirements including notice, affidavit and disclosure requirements.

- Procedures for surrendering and non-renewal of licenses of any line or all lines of business by insurers licensed to write insurance in Rhode Island must comply with the filing requirements mandated under 230-RICR-20-45-2 (formerly Insurance Regulation 58), where applicable.

- Insurers withdrawing from a line of business and/or cessation of new or renewal business must comply with all applicable non-renewal and cancellation provisions provided above. Withdrawal plans including cessation of business (new and renewal) must be submitted in SERFF. The insurer must fully explain the withdrawal, including a summary of policies and agents impacted, and insurers acknowledgement of compliance with all cancellation and non-renewal provisions including compliance with RIGL §27-2.4-20.

📌 The above-noted statutory references may not be all an inclusive list; rather, the above references are intended to aid in preparing filings and/or compliance related matters. The Department issues a Bulletin yearly that provides a legislative update in accordance with RIGL § 27-71-14. It is the licensees' responsibility to keep current with applicable RI statutes, Regulations and Insurance Bulletins issued by this Department. If you would like to be added to the Department's E-Mail Distribution List to receive notices of all Insurance Division news, bulletins, and regulations, please enter your email address in the box provided by clicking here.

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