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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2004

A N A C T

RELATING TO INSURANCE

Introduced By: Representative Peter T. Ginaitt

Date Introduced: February 24, 2004

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Section 27-18.5-2 of the General Laws in Chapter 27-18.5 entitled "Individual Health Insurance Coverage" is hereby amended to read as follows:

27-18.5-2. Definitions. -- The following words and phrases as used in this chapter have the following meanings unless a different meaning is required by the context:

(1) "Bona fide association" means, with respect to health insurance coverage offered in this state, an association which:

(i) Has been actively in existence for at least five (5) years;

(ii) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(iii) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(iv) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member);

(v) Does not make health insurance coverage offered through the association available other than in connection with a member of the association;

(vi) Is composed of persons having a common interest or calling;

(vii) Has a constitution and bylaws; and

(viii) Meets any additional requirements that the director may prescribe by regulation;

(2) "COBRA continuation provision" means any of the following:

(i) Section 4980(B) of the Internal Revenue Code of 1986, 26 U.S.C. section 4980B, other than subsection (f)(1) of that section insofar as it relates to pediatric vaccines;

(ii) Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1161 et seq., other than Section 609 of that act, 29 U.S.C. section 1169; or

(iii) Title XXII of the United States Public Health Service Act, 42 U.S.C. section 300bb-1 et seq.;

(3) "Creditable coverage" has the same meaning as defined in the United States Public Health Service Act, Section 2701(c), 42 U.S.C. section 300gg(c), as added by P.L. 104-191;

(4) "Director" means the director of the department of business regulation;

(5) "Eligible individual" means an individual:

(i) For whom, as of the date on which the individual seeks coverage under this chapter, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, a governmental plan established or maintained for its employees by the government of the United States or by any of its agencies or instrumentalities, or church plan (as defined by the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001 et seq.);

(ii) Who is not eligible for coverage under a group health plan, part A or part B of title XVIII of the Social Security Act, 42 U.S.C. section 1395c et seq. or 42 U.S.C. section 1395j et seq., or any state plan under title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq. (or any successor program), and does not have other health insurance coverage;

(iii) With respect to whom the most recent coverage within the coverage period was not terminated based on a factor described in section 27-18.5-4(b)(relating to nonpayment of premiums or fraud);

(iv) If the individual had been offered the option of continuation coverage under a COBRA continuation provision, or under chapter 19.1 of this title or under a similar state program of this state or any other state, who elected the coverage; and

(v) Who, if the individual elected COBRA continuation coverage, has exhausted the continuation coverage under the provision or program;

(6) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through

insurance, reimbursement or otherwise;

(7) "Health insurance carrier" or "carrier" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a nonprofit hospital, medical or dental service corporation, or any other entity providing a plan of health insurance or health benefits~~;~~ by which health care services are paid or financed for an eligible individual or his or her dependents by such entity on the basis of a periodic premium, paid directly or through an association, trust, or other intermediary, and issued, renewed, or delivered within or without Rhode Island to cover a natural person who is a resident of this state, including a certificate issued to a natural person which evidences coverage under a policy or contract issued to a trust or association;

(8) (i) "Health insurance coverage" means a policy, contract, certificate, or agreement offered by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(ii) "Health insurance coverage" does not include one or more, or any combination of, the following:

(A) Coverage only for accident, or disability income insurance, or any combination of those;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics;

(H) Other similar insurance coverage, specified in federal regulations issued pursuant to P.L. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits; and

(I) Short term limited duration insurance;

(iii) "Health insurance coverage" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are not an integral part of the coverage:

(A) Limited scope dental or vision benefits;

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;

(C) Any other similar, limited benefits that are specified in federal regulation issued pursuant to P.L. 104-191;

(iv) "Health insurance coverage" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor:

(A) Coverage only for a specified disease or illness; or

(B) Hospital indemnity or other fixed indemnity insurance; and

(v) "Health insurance coverage" does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

(A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, 42 U.S.C. section 1395ss(g)(1);

(B) Coverage supplemental to the coverage provided under 10 U.S.C. section 1071 et seq.; and

(C) Similar supplemental coverage provided to coverage under a group health plan;

(9) "Health status-related factor" means any of the following factors:

(i) Health status;

(ii) Medical condition, including both physical and mental illnesses;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

(vii) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(viii) Disability;

(10) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan;

(11) "Network plan" means health insurance coverage offered by a health insurance carrier under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under

contract with the carrier; and

(12) "Preexisting condition" means, with respect to health insurance coverage, a condition (whether physical or mental), regardless of the cause of the condition, that was present before the date of enrollment for the coverage, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information.

SECTION 2. Sections 27-50-3 and 27-50-4 of the General Laws in Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" are hereby amended to read as follows:

27-50-3. Definitions. -- (a) "Actuarial certification" means a written statement signed by a member of the American Academy of Actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 27-50-5, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(b) "Adjusted community rating" means a method used to develop a carrier's premium which spreads financial risk across the carrier's entire small group population in accordance with the requirements in section 27-50-5.

(c) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries controls or is controlled by, or is under common control with, a specified entity or person.

(d) "Affiliation period" means a period of time that must expire before health insurance coverage provided by a carrier becomes effective, and during which the carrier is not required to provide benefits.

(e) "Bona fide association" means, with respect to health benefit plans offered in this state, an association which:

(1) Has been actively in existence for at least five (5) years;

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(3) Does not condition membership in the association on any health-status related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to those members (or individuals

eligible for coverage through a member);

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association;

(6) Is composed of persons having a common interest or calling;

(7) Has a constitution and bylaws; and

(8) Meets any additional requirements that the director may prescribe by regulation.

(f) "Carrier" or "small employer carrier" means all entities licensed, or required to be licensed, in this state that offer health benefit plans covering eligible employees of one or more small employers pursuant to this chapter. For the purposes of this chapter, carrier includes an insurance company, a nonprofit hospital or medical service corporation, a fraternal benefit society, a health maintenance organization as defined in chapter 41 of this title or as defined in chapter 62 of title 42, or any other entity ~~providing a plan of health insurance or health benefits~~ subject to state insurance regulation~~.~~ that provides medical care as defined in subsection (y) that is paid or financed for a small employer by such entity on the basis of a periodic premium, paid directly or through an association, trust, or other intermediary, and issued, renewed, or delivered within or without Rhode Island to a small employer pursuant to the laws or this or any other jurisdiction, including a certificate issued to an eligible employee which evidences coverage under a policy or contract issued to a trust or association.

(g) "Church plan" has the meaning given this term under section 3(33) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. section 1002(33)].

(h) "Control" is defined in the same manner as in chapter 35 of this title.

(i) (1) "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

(i) A group health plan;

(ii) A health benefit plan;

(iii) Part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. section 1395c et seq., or 42 U.S.C. section 1395j et seq., (Medicare);

(iv) Title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq., (Medicaid), other than coverage consisting solely of benefits under 42 U.S.C. section 1396s (the program for distribution of pediatric vaccines);

(v) 10 U.S.C. section 1071 et seq., (medical and dental care for members and certain former members of the uniformed services, and for their dependents)(Civilian Health and Medical Program of the Uniformed Services)(CHAMPUS). For purposes of 10 U.S.C. section 1071 et seq., "uniformed services" means the armed forces and the commissioned corps of the

national oceanic and atmospheric administration and of the public health service;

(vi) A medical care program of the Indian Health Service or of a tribal organization;

(vii) A state health benefits risk pool;

(viii) A health plan offered under 5 U.S.C. section 8901 et seq., (Federal Employees Health Benefits Program (FEHBP));

(ix) A public health plan, which for purposes of this chapter, means a plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals enrolled in the plan; or

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, the individual experiences a significant break in coverage.

(j) "Dependent" means a spouse, an unmarried child under the age of nineteen (19) years, an unmarried child who is a full-time student under the age of twenty-five (25) years and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

(k) "Director" means the director of the department of business regulation.

(l) "Economy health plan" means a lower cost health benefit plan developed pursuant to the provisions of section 27-50-10.

(m) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the term shall also include an employee who works on a full-time basis with a normal work week of anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this eligibility criterion is applied uniformly among all of the employer's employees and without regard to any health status-related factor. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis or who works less than seventeen and one-half (17.5) hours per week. Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation requirements pursuant to section 27- 50-7(d)(9).

(n) "Enrollment date" means the first day of coverage or, if there is a waiting period, the first day of the waiting period, whichever is earlier.

(o) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(p) "Family composition" means:

(1) Enrollee;

(2) Enrollee, spouse and children;

(3) Enrollee and spouse; or

(4) Enrollee and children.

(q) "Genetic information" means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

(r) "Governmental plan" has the meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(32),and any federal governmental plan.

(s) (1) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the extent that the plan provides medical care, as defined in subsection (y) of this section, and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(2) For purposes of this chapter:

(i) Any plan, fund, or program that would not be, but for PHSA Section 2721(e), 42 U.S.C. section 300gg(e), as added by P.L. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph (ii) of this subdivision, as an employee welfare benefit plan that is a group health plan;

(ii) In the case of a group health plan, the term "employer" also includes the partnership in relation to any partner; and

(iii) In the case of a group health plan, the term "participant" also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary who is, or may become, eligible to receive a benefit under the plan, if:

(A) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership; or

(B) In connection with a group health plan maintained by a self-employed individual, under which one or more employees are participants, the individual is the self-employed individual.

(t) (1) "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, hospital or medical service corporation subscriber contract, or health maintenance organization subscriber contract. Health benefit plan includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

(2) "Health benefit plan" does not include one or more, or any combination of, the following:

(i) Coverage only for accident or disability income insurance, or any combination of those;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; and

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those; or

(iii) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination

between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, 42 U.S.C. section 1395ss(g)(1);

(ii) Coverage supplemental to the coverage provided under 10 U.S.C. section 1071 et seq.; or

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(6) A carrier offering policies or certificates of specified disease, hospital confinement indemnity, or limited benefit health insurance shall comply with the following:

(i) The carrier files on or before March 1 of each year a certification with the director that contains the statement and information described in paragraph (ii) of this subdivision;

(ii) The certification required in paragraph (i) of this subdivision shall contain the following:

(A) A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance; and

(B) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age or other factors) charged for those policies and certificates in this state; and

(iii) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after July 13, 2000, the carrier shall file with the director the information and statement required in paragraph (ii) of this subdivision at least thirty (30) days prior to the date the policy or certificate is issued or delivered in this state.

(u) "Health maintenance organization" or "HMO" means a health maintenance organization licensed under chapter 41 of this title.

(v) "Health status-related factor" means any of the following factors:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence; or

(8) Disability.

(w) (1) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days.

(2) "Late enrollee" does not mean an eligible employee or dependent:

(i) Who meets each of the following provisions:

(A) The individual was covered under creditable coverage at the time of the initial enrollment;

(B) The individual lost creditable coverage as a result of cessation of employer contribution, termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of creditable coverage, or death of a spouse, divorce or legal separation, or the individual and/or dependents are determined to be eligible for RIteCare under chapter 5.1 of title 40 or chapter 12.3 of title 42 or for RIteShare under chapter 8.4 of title 40; and

(C) The individual requests enrollment within thirty (30) days after termination of the creditable coverage or the change in conditions that gave rise to the termination of coverage;

(ii) If, where provided for in contract or where otherwise provided in state law, the individual enrolls during the specified bona fide open enrollment period;

(iii) If the individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;

(iv) If a court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and a request for enrollment is made within thirty (30) days after issuance of the court order;

(v) If the individual changes status from not being an eligible employee to becoming an eligible employee and requests enrollment within thirty (30) days after the change in status;

(vi) If the individual had coverage under a COBRA continuation provision and the coverage under that provision has been exhausted; or

(vii) Who meets the requirements for special enrollment pursuant to section 27-50-7 or 27-50-8.

(x) "Limited benefit health insurance" means that form of coverage that pays stated predetermined amounts for specific services or treatments or pays a stated predetermined amount per day or confinement for one or more named conditions, named diseases or accidental injury.

(y) "Medical care" means amounts paid for:

(1) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in subdivision (1); and

(3) Insurance covering medical care referred to in subdivisions (1) and (2) of this subsection.

(z) "Network plan" means a health benefit plan issued by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

(aa) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(bb) "Plan sponsor" has the meaning given this term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(16)(B).

(cc) (1) "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the enrollment date of the coverage.

(2) "Preexisting condition" does not mean a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the health benefit plan, provided that the prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.

(3) Genetic information shall not be treated as a condition under subdivision (1) of this subsection for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.

(dd) "Premium" means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(ee) "Producer" means any insurance producer licensed under chapter 2.4 of this title.

(ff) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(gg) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to provide health care services to covered individuals.

(hh) "Risk adjustment mechanism" means the mechanism established pursuant to section 27-50-16.

(ii) "Self-employed individual" means an individual or sole proprietor who derives a substantial portion of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

(jj) "Significant break in coverage" means a period of ninety (90) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

(kk) "Small employer" means, except for its use in section 27-50-7, any person, firm, corporation, partnership, association, political subdivision, or self-employed individual that is actively engaged in business including, but not limited to, a business or a corporation organized under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of another state that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week of thirty (30) or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term small employer includes a self-employed individual.

(ll) "Standard health benefit plan" means a health benefit plan developed pursuant to

the provisions of section 27-50-10.

(mm) "Waiting period" means, with respect to a group health plan and an individual who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to subsection ~~(j)~~(i)(2) of this section, a waiting period shall not be considered a gap in coverage.

(nn) "Affordable health benefit plan" means a health benefit plan that is designed to promote health, i.e. disease prevention, wellness, disease management, preventive care, and/or similar health and wellness programs; that is actively marketed by a carrier in accordance with this chapter; and that may be modified or terminated by a carrier in accordance with section 27-50-6.

27-50-4. Applicability and scope. -- (a) This chapter applies to any health benefit plan that provides coverage to the employees of a small employer in this state, whether issued directly by a carrier or through a trust, association, or other intermediary, and regardless of the jurisdiction of issuance or delivery of the policy, if any of the following conditions are met:

(1) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125, or Section 106 of the United States Internal Revenue Code, 26 U.S.C. section 162, 125, or 106; or

(4) The health benefit plan is marketed to individual employees through an employer.

(b) (1) Except as provided in subdivision (2) of this subsection, for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier.

(2) An affiliated carrier that is a health maintenance organization having a license under chapter 41 of this title or a health maintenance organization as defined in chapter 62 of title 42 may be considered to be a separate carrier for the purposes of this chapter.

(3) Unless otherwise authorized by the director, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if those arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for the health benefit plans being retained by the

ceding carrier. The department of business regulation's statutory provisions under this title shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.

SECTION 3. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE

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This act would provide the department of business regulation with the authority to regulate insurance companies offering small group and individual market health insurance by means of out-of-state trusts and associations.

This act would take effect upon passage.

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