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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2012

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A N A C T

RELATING TO INSURANCE -- HEALTH INSURANCE - CONSUMER PROTECTION

Introduced By: Representatives Kennedy, San Bento, E Coderre, Ferri, and Tanzi

Date Introduced: March 07, 2012

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Purpose and intent.

2 It is the purpose of this act to amend Rhode Island statutes so as to be consistent with
3 health insurance consumer protections enacted in federal law. This act is intended to establish
4 health insurance rules, standards, and policies pursuant to, and in furtherance of, the health
5 insurance standards established in the federal Patient Protection and Affordable Care Act of 2010,
6 as amended by the federal Health Care and Education Reconciliation Act of 2010.

7 SECTION 2. Chapter 27-18 of the General laws entitled "Accident and Sickness
8 Insurance Policies" is hereby amended by adding thereto the following sections:

9 **27-18-1.1. Definitions.** – As used in this chapter:

10 (1) "Adverse benefit determination" means any of the following: a denial, reduction, or
11 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,
12 including any such denial, reduction, termination, or failure to provide or make payment that is
13 based on a determination of an individual's eligibility to participate in a plan or to receive
14 coverage under a plan, and including, with respect to group health plans, a denial, reduction, or
15 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit
16 resulting from the application of any utilization review, as well as a failure to cover an item or
17 service for which benefits are otherwise provided because it is determined to be experimental or
18 investigational or not medically necessary or appropriate. The term also includes a rescission of
19 coverage determination.

1 (2) “Affordable Care Act” means the federal Patient Protection and Affordable Care Act
2 of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and
3 federal regulations adopted thereunder.

4 (3) “Commissioner” or “health insurance commissioner” means that individual appointed
5 pursuant to section 42-14.5-1 of the general laws.

6 (4) “Essential health benefits” shall have the meaning set forth in section 1302(b) of the
7 federal Affordable Care Act.

8 (5) “Grandfathered health plan” means any group health plan or health insurance
9 coverage subject to 42 USC section 18011.

10 (6) “Group health insurance coverage” means, in connection with a group health plan,
11 health insurance coverage offered in connection with such plan.

12 (7) “Group health plan” means an employee welfare benefit plan, as defined in 29 USC
13 section 1002(1), to the extent that the plan provides health benefits to employees or their
14 dependents directly or through insurance, reimbursement, or otherwise.

15 (8) “Health benefits” or “covered benefits” means coverage or benefits for the diagnosis,
16 cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting
17 any structure or function of the body including coverage or benefits for transportation primarily
18 for and essential thereto, and including medical services as defined in R.I. Gen. Laws § 27-19-17;

19 (9) “Health care facility” means an institution providing health care services or a health
20 care setting, including, but not limited to, hospitals and other licensed inpatient centers,
21 ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers,
22 diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health
23 settings.

24 (10) “Health care professional” means a physician or other health care practitioner
25 licensed, accredited or certified to perform specified health care services consistent with state
26 law.

27 (11) “Health care provider” or “provider” means a health care professional or a health
28 care facility.

29 (12) “Health care services” means services for the diagnosis, prevention, treatment, cure
30 or relief of a health condition, illness, injury or disease.

31 (13) “Health insurance carrier” means a person, firm, corporation or other entity subject
32 to the jurisdiction of the commissioner under this chapter. Such term does not include a group
33 health plan.

34 (14) “Health plan” or “health benefit plan” means health insurance coverage and a group

1 health plan, including coverage provided through an association plan if it covers Rhode Island
2 residents. Except to the extent specifically provided by the federal Affordable Care Act, the term
3 “health plan” shall not include a group health plan to the extent state regulation of the health plan
4 is pre-empted under section 514 of the federal Employee Retirement Income Security Act of
5 1974. The term also shall not include:

6 (A)(i) Coverage only for accident, or disability income insurance, or any combination
7 thereof.

8 (ii) Coverage issued as a supplement to liability insurance.

9 (iii) Liability insurance, including general liability insurance and automobile liability
10 insurance.

11 (iv) Workers’ compensation or similar insurance.

12 (v) Automobile medical payment insurance.

13 (vi) Credit-only insurance.

14 (vii) Coverage for on-site medical clinics.

15 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant to
16 Pub. L. No. 104-191, the federal health insurance portability and accountability act of 1996
17 (“HIPAA”), under which benefits for medical care are secondary or incidental to other insurance
18 benefits.

19 (B) The following benefits if they are provided under a separate policy, certificate or
20 contract of insurance or are otherwise not an integral part of the plan:

21 (i) Limited scope dental or vision benefits.

22 (ii) Benefits for long-term care, nursing home care, home health care, community-based
23 care, or any combination thereof.

24 (iii) Other excepted benefits specified in federal regulations issued pursuant to federal
25 Pub. L. No. 104-191 (“HIPAA”).

26 (C) The following benefits if the benefits are provided under a separate policy, certificate
27 or contract of insurance, there is no coordination between the provision of the benefits and any
28 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the
29 benefits are paid with respect to an event without regard to whether benefits are provided with
30 respect to such an event under any group health plan maintained by the same plan sponsor:

31 (i) Coverage only for a specified disease or illness.

32 (ii) Hospital indemnity or other fixed indemnity insurance.

33 (D) The following if offered as a separate policy, certificate or contract of insurance:

34 (i) Medicare supplement health insurance as defined under section 1882(g)(1) of the

1 federal Social Security Act.

2 (ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United
3 States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

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

5 (15) "Office of the health insurance commissioner" means the agency established under
6 section 42-14.5-1 of the General laws.

7 (16) "Rescission" means a cancellation or discontinuance of coverage that has retroactive
8 effect for reasons unrelated to timely payment of required premiums or contribution to costs of
9 coverage.

10 **27-18-2.1. Uniform explanation of benefits and coverage.** – (a) A health insurance
11 carrier shall provide a summary of benefits and coverage explanation and definitions to
12 policyholders and others required by, and at the times and in the format required, by the federal
13 regulations adopted under section 2715 of the Public Health Service Act, as amended by the
14 federal Affordable Care Act. The forms required by this section shall be made available to the
15 commissioner on request. Nothing in this section shall be construed to limit the authority of the
16 commissioner under existing state law.

17 (b) The provisions of this section shall apply to grandfathered health plans. This section
18 shall not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity;
19 (2) disability income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited
20 benefit health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident
21 or both; and (9) other limited benefit policies.

22 (c) If the commissioner of the office of the health insurance commissioner determines
23 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
24 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
25 an act of Congress, on the date of the commissioner's determination this section shall have its
26 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
27 section. Nothing in this section shall be construed to limit the authority of the commissioner
28 under existing state law.

29 **27-18-71. Prohibition on preexisting condition exclusions.** – (a) A health insurance
30 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a
31 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

32 (1) Shall not limit or exclude coverage for an individual under the age of nineteen (19) by
33 imposing a preexisting condition exclusion on that individual.

34 (2) For plan or policy years beginning on or after January 1, 2014, shall not limit or

1 exclude coverage for any individual by imposing a preexisting condition exclusion on that
2 individual.

3 (b) As used in this section:

4 (1) “Preexisting condition exclusion” means a limitation or exclusion of benefits,
5 including a denial of coverage, based on the fact that the condition (whether physical or mental)
6 was present before the effective date of coverage, or if the coverage is denied, the date of denial,
7 under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was
8 recommended or received before the effective date of coverage.

9 (2) “Preexisting condition exclusion” means any limitation or exclusion of benefits,
10 including a denial of coverage, applicable to an individual as a result of information relating to an
11 individual’s health status before the individual’s effective date of coverage, or if the coverage is
12 denied, the date of denial, under the health benefit plan, such as a condition (whether physical or
13 mental) identified as a result of a pre-enrollment questionnaire or physical examination given to
14 the individual, or review of medical records relating to the pre-enrollment period.

15 (c) This section shall not apply to grandfathered health plans providing individual health
16 insurance coverage.

17 (d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
18 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
19 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
20 bodily injury or death by accident or both; and (9) Other limited benefit policies.

21 **27-18-72. Prohibition on rescission of coverage.** – (a)(1) Coverage under a health
22 benefit plan subject to the jurisdiction of the commissioner under this chapter with respect to an
23 individual, including a group to which the individual belongs or family coverage in which the
24 individual is included, shall not be rescinded after the individual is covered under the plan,
25 unless:

26 (A) The individual or a person seeking coverage on behalf of the individual, performs an
27 act, practice or omission that constitutes fraud; or

28 (B) The individual makes an intentional misrepresentation of material fact, as prohibited
29 by the terms of the plan or coverage.

30 (2) For purposes of paragraph (a)(1)(A), a person seeking coverage on behalf of an
31 individual does not include an insurance producer or employee or authorized representative of the
32 health carrier.

33 (b) At least thirty (30) days advance written notice shall be provided to each health
34 benefit plan enrollee or, for individual health insurance coverage, primary subscriber, who would

1 be affected by the proposed rescission of coverage before coverage under the plan may be
2 rescinded in accordance with subsection (a) regardless of, in the case of group health insurance
3 coverage, whether the rescission applies to the entire group or only to an individual within the
4 group.

5 (c) For purposes of this section, “to rescind” means to cancel or to discontinue coverage
6 with retroactive effect for reasons unrelated to timely payment of required premiums or
7 contribution to costs of coverage.

8 (d) This section applies to grandfathered health plans.

9 **27-18-73. Prohibition on annual and lifetime limits. – (a) Annual limits.**

10 (1) For plan or policy years beginning prior to January 1, 2014, for any individual, a
11 health insurance carrier and a health benefit plan subject to the jurisdiction of the commissioner
12 under this chapter may establish an annual limit on the dollar amount of benefits that are essential
13 health benefits provided the restricted annual limit is not less than the following:

14 (A) For a plan or policy year beginning after September 22, 2011, but before September
15 23, 2012 – one million two hundred fifty thousand dollars (\$1,250,000); and

16 (B) For a plan or policy year beginning after September 22, 2012, but before January 1,
17 2014 – two million dollars (\$2,000,000).

18 (2) For plan or policy years beginning on or after January 1, 2014, a health insurance
19 carrier and a health benefit plan shall not establish any annual limit on the dollar amount of
20 essential health benefits for any individual, except:

21 (A) A health flexible spending arrangement, as defined in Section 106(c)(2)(i) of the
22 Federal Internal Revenue Code, a medical savings account, as defined in section 220 of the
23 federal Internal Revenue Code, and a health savings account, as defined in Section 223 of the
24 federal Internal Revenue Code are not subject to the requirements of subdivisions (1) and (2) of
25 this subsection.

26 (B) The provisions of this subsection shall not prevent a health insurance carrier and a
27 health benefit plan from placing annual dollar limits for any individual on specific covered
28 benefits that are not essential health benefits to the extent that such limits are otherwise permitted
29 under applicable federal law or the laws and regulations of this state.

30 (3) In determining whether an individual has received benefits that meet or exceed the
31 allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier and a
32 health benefit plan shall take into account only essential health benefits.

33 (b) Lifetime limits.

34 (1) A health insurance carrier and health benefit plan offering group or individual health

1 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
2 benefits for any individual.

3 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
4 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
5 benefits that are not essential health benefits, in accordance with federal laws and regulations.

6 (c)(1) The provisions of this section relating to lifetime limits apply to any health
7 insurance carrier providing coverage under an individual or group health plan, including
8 grandfathered health plans.

9 (2) The provisions of this section relating to annual limits apply to any health insurance
10 carrier providing coverage under a group health plan, including grandfathered health plans, but
11 the prohibition and limits on annual limits do not apply to grandfathered health plans providing
12 individual health insurance coverage.

13 (d) This section shall not apply to a plan or to policy years prior to January 1, 2014 for
14 which the Secretary of the U.S. Department of Health and Human Services issued a waiver
15 pursuant to 45 C.F.R. § 147.126(d)(3). This section also shall not apply to insurance coverage
16 providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident
17 only; (4) long term care; (5) Medicare supplement; (6) limited benefit health; (7) specified disease
18 indemnity; (8) sickness or bodily injury or death by accident or both; and (9) other limited benefit
19 policies.

20 (e) If the commissioner of the office of the health insurance commissioner determines
21 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
22 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
23 an act of Congress, on the date of the commissioner's determination this section shall have its
24 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
25 section. Nothing in this subsection shall be construed to limit the authority of the Commissioner
26 to regulate health insurance under existing state law.

27 **27-18-74. Coverage for individuals participating in approved clinical trials. – (a) As**
28 **used in this section.**

29 (1) “Approved clinical trial” means a phase I, phase II, phase III or phase IV clinical trial
30 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
31 threatening disease or condition and is described in any of the following:

32 (A) The study or investigation is approved or funded, which may include funding through
33 in-kind contributions, by one or more of the following:

34 (i) The federal National Institutes of Health;

1 (ii) The federal Centers for Disease Control and Prevention;
2 (iii) The federal Agency for Health Care Research and Quality;
3 (iv) The federal Centers for Medicare & Medicaid Services;
4 (v) A cooperative group or center of any of the entities described in items (i) through (iv)
5 or the U.S. Department of Defense or the U.S. Department of Veteran Affairs;
6 (vi) A qualified non-governmental research entity identified in the guidelines issued by
7 the federal National Institutes of Health for center support grants; or
8 (vii) A study or investigation conducted by the U.S. Department of Veteran Affairs, the
9 U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has
10 been reviewed and approved through a system of peer review that the Secretary of U.S.
11 Department of Health and Human Services determines:
12 (I) Is comparable to the system of peer review of studies and investigations used by the
13 federal National Institutes of Health; and
14 (II) Assures unbiased review of the highest scientific standards by qualified individuals
15 who have no interest in the outcome of the review.
16 (B) The study or investigation is conducted under an investigational new drug application
17 reviewed by the U.S. Food and Drug Administration; or
18 (C) The study or investigation is a drug trial that is exempt from having such an
19 investigational new drug application.
20 (2) “Participant” has the meaning stated in section 3(7) of federal ERISA.
21 (3) “Participating provider” means a health care provider that, under a contract with the
22 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
23 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
24 deductibles, directly or indirectly from the health carrier.
25 (4) “Qualified individual” means a participant or beneficiary who meets the following
26 conditions:
27 (A) The individual is eligible to participate in an approved clinical trial according to the
28 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;
29 and
30 (B)(i) The referring health care professional is a participating provider and has concluded
31 that the individual’s participation in such trial would be appropriate based on the individual
32 meeting the conditions described in subdivision (A) of this subdivision (3); or
33 (ii) The participant or beneficiary provides medical and scientific information
34 establishing the individual’s participation in such trial would be appropriate based on the

1 individual meeting the conditions described in subdivision (A) of this subdivision (3).

2 (5) “Life-threatening condition” means any disease or condition from which the
3 likelihood of death is probable unless the course of the disease or condition is interrupted.

4 (b)(1) If a health insurance carrier offering group or individual health insurance coverage
5 provides coverage to a qualified individual, the health insurance carrier:

6 (A) Shall not deny the individual participation in an approved clinical trial.

7 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose
8 additional conditions on the coverage of routine patient costs for items and services furnished in
9 connection with participation in the approved clinical trial; and

10 (C) Shall not discriminate against the individual on the basis of the individual’s
11 participation in the approved clinical trial.

12 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all
13 items and services consistent with the coverage typically covered for a qualified individual who is
14 not enrolled in an approved clinical trial.

15 (B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not
16 include:

17 (i) The investigational item, device or service itself;

18 (ii) Items and services that are provided solely to satisfy data collection and analysis
19 needs and that are not used in the direct clinical management of the patient; or

20 (iii) A service that is clearly inconsistent with widely accepted and established standards
21 of care for a particular diagnosis.

22 (3) If one or more participating providers are participating in a clinical trial, nothing in
23 subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring
24 that a qualified individual participate in the trial through such a participating provider if the
25 provider will accept the individual as a participant in the trial.

26 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection
27 shall apply to a qualified individual participating in an approved clinical trial that is conducted
28 outside this state.

29 (5) This section shall not be construed to require a health insurance carrier offering group
30 or individual health insurance coverage to provide benefits for routine patient care services
31 provided outside of the coverage’s health care provider network unless out-of-network benefits
32 are otherwise provided under the coverage.

33 (6) Nothing in this section shall be construed to limit a health insurance carrier’s
34 coverage with respect to clinical trials.

1 (c) The requirements of this section shall be in addition to the requirements of Rhode
2 Island general laws sections 27-18-36 through 27-18-36.3.

3 (d) This section shall not apply to grandfathered health plans. This section shall not apply
4 to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability
5 income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit
6 health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both;
7 and (9) other limited benefit policies.

8 (e) This section shall be effective for plan years beginning on or after January 1, 2014.

9 **27-18-75. Medical loss ratio reporting and rebates.** – (a) A health insurance carrier
10 offering group or individual health insurance coverage of a health benefit plan, including a
11 grandfathered health plan, shall comply with the provisions of Section 2718 of the Public Health
12 Services Act as amended by the federal Affordable Care Act, in accordance with regulations
13 adopted thereunder.

14 (b) Health insurance carriers required to report medical loss ratio and rebate calculations
15 and other medical loss ratio and rebate information to the U.S. Department of Health and Human
16 Services shall concurrently file such information with the commissioner.

17 **27-18-76. Emergency services.** – (a) As used in this section:

18 (1) “Emergency medical condition” means a medical condition manifesting itself by
19 acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
20 possesses an average knowledge of health and medicine, could reasonably expect the absence of
21 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
22 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
23 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
24 part.

25 (2) “Emergency services” means, with respect to an emergency medical condition:

26 (A) A medical screening examination (as required under section 1867 of the Social
27 Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a
28 hospital, including ancillary services routinely available to the emergency department to evaluate
29 such emergency medical condition, and

30 (B) Such further medical examination and treatment, to the extent they are within the
31 capabilities of the staff and facilities available at the hospital, as are required under section 1867
32 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

33 (3) “Stabilize”, with respect to an emergency medical condition has the meaning given in
34 section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

1 (b) If a health insurance carrier offering health insurance coverage provides any benefits
2 with respect to services in an emergency department of a hospital, the carrier must cover
3 emergency services in compliance with this section.

4 (c) A health insurance carrier shall provide coverage for emergency services in the
5 following manner:

6 (1) Without the need for any prior authorization determination, even if the emergency
7 services are provided on an out-of-network basis;

8 (2) Without regard to whether the health care provider furnishing the emergency services
9 is a participating network provider with respect to the services;

10 (3) If the emergency services are provided out of network, without imposing any
11 administrative requirement or limitation on coverage that is more restrictive than the requirements
12 or limitations that apply to emergency services received from in-network providers;

13 (4) If the emergency services are provided out of network, by complying with the cost-
14 sharing requirements of subsection (d) of this section; and

15 (5) Without regard to any other term or condition of the coverage, other than:

16 (A) The exclusion of or coordination of benefits;

17 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
18 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

19 (C) Applicable cost-sharing.

20 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
21 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
22 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
23 the services were provided in-network; provided, however, that a participant or beneficiary may
24 be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-
25 network provider charges over the amount the health insurance carrier is required to pay under
26 subdivision (1) of this subsection. A health insurance carrier complies with the requirements of
27 this subsection if it provides benefits with respect to an emergency service in an amount equal to
28 the greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision
29 (1)(which are adjusted for in-network cost-sharing requirements).

30 (A) The amount negotiated with in-network providers for the emergency service
31 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
32 participant or beneficiary. If there is more than one amount negotiated with in-network providers
33 for the emergency service, the amount described under this subdivision (A) is the median of these
34 amounts, excluding any in-network copayment or coinsurance imposed with respect to the

1 participant or beneficiary. In determining the median described in the preceding sentence, the
2 amount negotiated with each in-network provider is treated as a separate amount (even if the
3 same amount is paid to more than one provider). If there is no per-service amount negotiated with
4 in-network providers (such as under a capitation or other similar payment arrangement), the
5 amount under this subdivision (A) is disregarded.

6 (B) The amount for the emergency service shall be calculated using the same method the
7 plan generally uses to determine payments for out-of-network services (such as the usual,
8 customary, and reasonable amount), excluding any in-network copayment or coinsurance
9 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
10 determined without reduction for out-of-network cost-sharing that generally applies under the
11 plan or health insurance coverage with respect to out-of-network services.

12 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
13 Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network
14 copayment or coinsurance imposed with respect to the participant or beneficiary.

15 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
16 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
17 services provided out of network if the cost-sharing requirement generally applies to out-of-
18 network benefits. A deductible may be imposed with respect to out-of-network emergency
19 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
20 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
21 apply to out-of-network emergency services.

22 (e) The provisions of this section apply for plan years beginning on or after September
23 23, 2010.

24 (f) This section shall not apply to grandfathered health plans. This section shall not apply
25 to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability
26 income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit
27 health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both;
28 and (9) other limited benefit policies.

29 **27-18-77. Internal and external appeal of adverse benefit determinations.** – (a) The
30 commissioner shall adopt regulations to implement standards and procedures with respect to
31 internal claims and appeals of adverse benefit determinations, and with respect to external appeals
32 of adverse benefit determinations.

33 (b) The regulations adopted by the commissioner shall apply only to those adverse
34 benefit determinations which are not subject to the jurisdiction of the department of health

1 [pursuant to R.I. Gen. Laws § 23-17.12 et seq. \(Utilization Review Act\).](#)

2 [\(c\) This section shall not apply to insurance coverage providing benefits for: \(1\) hospital](#)
3 [confinement indemnity; \(2\) disability income; \(3\) accident only; \(4\) long term care; \(5\) Medicare](#)
4 [supplement; \(6\) limited benefit health; \(7\) specified disease indemnity; \(8\) sickness or bodily](#)
5 [injury or death by accident or both; and \(9\) other limited benefit policies. This section also shall](#)
6 [not apply to grandfathered health plans.](#)

7 SECTION 3. Sections 27-18-8, 27-18-44 and 27-18-59 of the General laws in Chapter
8 27-18 entitled "Accident and Sickness Insurance Policies" are hereby amended to read as follows:

9 **27-18-8. Filing of accident and sickness insurance policy forms.** – (a) Any insurance
10 company authorized to do an accident and sickness business within this state in accordance with
11 the provisions of this title shall file all accident and sickness insurance policy forms and rates
12 used by it in the state with the insurance commissioner, including the forms of any rider,
13 endorsement, application blank, and other matter generally used or incorporated by reference in
14 its policies or contracts of insurance. [No such form shall be used if disapproved by the](#)
15 [commissioner under this section, or if the commissioner’s approval has been withdrawn under](#)
16 [section 27-18-8.3, or until the expiration of the waiting period established under section 27-18-](#)
17 [8.3. Such a company shall comply with its filed and approved forms.](#) If the commissioner finds
18 from a examination of any form that it is contrary to the public interest, or the requirements of
19 this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the
20 company in writing as provided in section 27-18-8.2. ~~Each form shall include a certification by a~~
21 ~~qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate is in~~
22 ~~compliance with applicable laws and that the benefits are reasonable in relation to the premium to~~
23 ~~be charged.~~

24 [\(b\) Each rate filing shall include a certification by a qualified actuary that to the best of](#)
25 [the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws](#)
26 [and that the benefits offered or proposed to be offered are reasonable in relation to the premium](#)
27 [to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.](#)

28 **27-18-44. Primary and preventive obstetric and gynecological care.** – (a) Any insurer
29 or [health plan](#), nonprofit health [medical](#) service plan, [or nonprofit hospital service plan](#) that
30 provides coverage for obstetric and gynecological care for issuance or delivery in the state to any
31 group or individual on an expense-incurred basis, including [a health plan offered or issued by a](#)
32 [health insurance carrier](#) or a health maintenance organization, shall permit a woman to receive an
33 annual visit to an in-network obstetrician/gynecologist for routine gynecological care without
34 requiring the woman to first obtain a referral from a primary care provider.

1 (b)(1)(A) Any health plan, nonprofit medical service plan or nonprofit hospital service
2 plan, including a health insurance carrier or a health maintenance organization which requires or
3 provides for the designation by a covered person of a participating primary health care
4 professional shall permit each covered person to:

5 (i) Designate any participating primary care health care professional who is available to
6 accept the covered person; and

7 (ii) For a child, designate any participating physician who specializes in pediatrics as the
8 child's primary care health care professional and is available to accept the child.

9 (2) The provisions of subdivision (1) of this subsection shall not be construed to waive
10 any exclusions of coverage under the terms and conditions of the health benefit plan with respect
11 to coverage of pediatric care.

12 (c)(1) If a health plan, nonprofit medical service plan or nonprofit hospital service plan,
13 including a health insurance carrier or a health maintenance organization, provides coverage for
14 obstetrical or gynecological care and requires the designation by a covered person of a
15 participating primary care health care professional, then it:

16 (A) Shall not require any person's, including a primary care health care professional's,
17 prior authorization or referral in the case of a female covered person who seeks coverage for
18 obstetrical or gynecological care provided by a participating health care professional who
19 specializes in obstetrics or gynecology; and

20 (B) Shall treat the provision of obstetrical and gynecological care, and the ordering of
21 related obstetrical and gynecological items and services, pursuant to subdivision (A) of this
22 subdivision (c)(1), by a participating health care professional who specializes in obstetrics or
23 gynecology as the authorization of the primary care health care professional.

24 (2)(A) A health plan, nonprofit medical service plan or nonprofit hospital service plan,
25 including a health insurance carrier or a health maintenance organization may require the health
26 care professional to agree to otherwise adhere to its policies and procedures, including procedures
27 relating to referrals, obtaining prior authorization, and providing services in accordance with a
28 treatment plan, if any, approved by the plan, carrier or health maintenance organization.

29 (B)For purposes of subdivision (A) of this subdivision (c)(1), a health care professional,
30 who specializes in obstetrics or gynecology, means any individual, including an individual other
31 than a physician, who is authorized under state law to provide obstetrical or gynecological care.

32 (3) The provisions of subdivision (A) of this subdivision (c)(1) shall not be construed to:

33 (A) Waive any exclusions of coverage under the terms and conditions of the health
34 benefit plan with respect to coverage of obstetrical or gynecological care; or

1 (B) Preclude the health plan, nonprofit medical service plan or nonprofit hospital service
2 plan, including a health insurance carrier or a health maintenance organization involved from
3 requiring that the participating health care professional providing obstetrical or gynecological
4 care notify the primary care health care professional or the plan, carrier or health maintenance
5 organization of treatment decisions.

6 (d) Notice Requirements:

7 (1) A health plan, nonprofit medical service plan or nonprofit hospital service plan,
8 including a health insurance carrier or a health maintenance organization subject to this section
9 shall provide notice to covered persons of the terms and conditions of the plan related to the
10 designation of a participating health care professional and of a covered person's rights with
11 respect to those provisions.

12 (2)(A) In the case of group health insurance coverage, the notice described in subdivision
13 (1) of this subsection shall be included whenever the a participant is provided with a summary
14 plan description or other similar description of benefits under the health benefit plan.

15 (B) In the case of individual health insurance coverage, the notice described in
16 subdivision (1) of this subsection shall be included whenever the primary subscriber is provided
17 with a policy, certificate or contract of health insurance.

18 (C) A health plan, nonprofit medical service plan or nonprofit hospital service plan,
19 including a health insurance carrier or a health maintenance organization, may use the model
20 language in federal regulation 45 CFR section 147.138(a)(4)(iii) to satisfy the requirements of
21 this subsection.

22 (e) The requirements of subsections (b), (c), and (d) shall not apply to grandfathered
23 health plans. This section shall not apply to insurance coverage providing benefits for: (1)
24 hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5)
25 Medicare supplement; (6) limited benefit health; (7) specified disease indemnity; (8) sickness or
26 bodily injury or death by accident or both; and (9) other limited benefit policies.

27 **27-18-59. Termination of children's benefits Eligibility for children's benefits. --**

28 (a)(1) Every ~~individual health insurance contract, plan, or policy~~ health benefit plan delivered,
29 issued for delivery, or renewed in this state and every group health insurance contract, plan, or
30 policy delivered, issued for delivery or renewed in this state which provides ~~medical~~ health
31 benefits coverage for ~~dependent children that includes coverage for physician services in a~~
32 ~~physician's office, and every policy which provides major medical or similar comprehensive type~~
33 ~~coverage~~ dependents, except for supplemental policies which only provide coverage for specified
34 diseases and other supplemental policies, shall ~~provide~~ make coverage ~~available of an unmarried~~

1 ~~child under the age of nineteen (19) years, an unmarried child who is a student under the age of~~
2 ~~twenty five (25) years and who is financially dependent upon the parent and an unmarried child~~
3 ~~of any age who is financially dependent upon the parent and medically determined to have a~~
4 ~~physical or mental impairment which can be expected to result in death or which has lasted or can~~
5 ~~be expected to last for a continuous period of not less than twelve (12) months~~ for children until
6 attainment of twenty-six (26) years of age, and an unmarried child of any age who is financially
7 dependent upon the parent and medically determined to have a physical or mental impairment
8 which can be expected to result in death or which has lasted or can be expected to last for a
9 continuous period of not less than twelve (12) months. ~~Such contract, plan or policy shall also~~
10 ~~include a provision that policyholders shall receive no less than thirty (30) days notice from the~~
11 ~~accident and sickness insurer that a child covered as a dependent by the policy holder is about to~~
12 ~~lose his or her coverage as a result of reaching the maximum age for a dependent child, and that~~
13 ~~the child will only continue to be covered upon documentation being provided of current full or~~
14 ~~part time enrollment in a post secondary educational institution or that the child may purchase a~~
15 ~~conversion policy if he or she is not an eligible student. Nothing in this section prohibits an~~
16 ~~accident and sickness insurer from requiring a policyholder to annually provide proof of a child's~~
17 ~~current full or part time enrollment in a post secondary educational institution in order to~~
18 ~~maintain the child's coverage. Provided, nothing in this section requires coverage inconsistent~~
19 ~~with the membership criteria in effect under the policyholder's health benefits coverage.~~

20 (2) With respect to a child who has not attained twenty-six (26) years of age, a health
21 insurance carrier shall not define "dependent" for purposes of eligibility for dependent coverage
22 of children other than the terms of a relationship between a child and the plan participant, or
23 subscriber.

24 (3) A health insurance carrier shall not deny or restrict coverage for a child who has not
25 attained twenty-six (26) years of age based on the presence or absence of the child's financial
26 dependency upon the participant, primary subscriber or any other person, residency with the
27 participant and in the individual market the primary subscriber, or with any other person, marital
28 status, student status, employment or any combination of those factors. A health carrier shall not
29 deny or restrict coverage of a child based on eligibility for other coverage, except as provided in
30 subparagraph (b)(1) of this section.

31 (4) Nothing in this section shall be construed to require a health insurance carrier to make
32 coverage available for the child of a child receiving dependent coverage, unless the grandparent
33 becomes the legal guardian or adoptive parent of that grandchild.

34 (5) The terms of coverage in a health benefit plan offered by a health insurance carrier

1 providing dependent coverage of children cannot vary based on age except for children who are
2 twenty-six (26) years of age or older.

3 (b)(1) For plan years beginning before January 1, 2014, a health insurance carrier
4 providing group health insurance coverage that is a grandfathered health plan and makes
5 available dependent coverage of children may exclude an adult child who has not attained twenty-
6 six (26) years of age from coverage only if the adult child is eligible to enroll in an eligible
7 employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the federal Internal
8 Revenue Code, other than the group health plan of a parent.

9 (2) For plan years, beginning on or after January 1, 2014, a health insurance carrier
10 providing group health insurance coverage that is a grandfathered health plan shall comply with
11 the requirements of subsections (a) through (e) of this section.

12 ~~(b)~~(c) This section does not apply to insurance coverage providing benefits for: (1)
13 hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5)
14 Medicare supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) sickness
15 or bodily injury or death by accident or both; or (9) other limited benefit policies.

16 SECTION 4. Chapter 27-18.5 of the General Laws entitled “Individual Health Insurance
17 Coverage” is hereby amended by adding thereto the following section:

18 **27-18.5-10. Prohibition on preexisting condition exclusions.** -- (a) A health insurance
19 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a
20 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

21 (1) Shall not limit or exclude coverage for an individual under the age of nineteen (19) by
22 imposing a preexisting condition exclusion on that individual.

23 (2) For plan or policy years beginning on or after January 1, 2014, shall not limit or
24 exclude coverage for any individual by imposing a preexisting condition exclusion on that
25 individual.

26 (b) As used in this section:

27 (1) “Preexisting condition exclusion” means a limitation or exclusion of benefits,
28 including a denial of coverage, based on the fact that the condition (whether physical or mental)
29 was present before the effective date of coverage, or if the coverage is denied, the date of denial,
30 under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was
31 recommended or received before the effective date of coverage.

32 (2) “Preexisting condition exclusion” means any limitation or exclusion of benefits,
33 including a denial of coverage, applicable to an individual as a result of information relating to an
34 individual’s health status before the individual’s effective date of coverage, or if the coverage is

1 denied, the date of denial, under the health benefit plan, such as a condition (whether physical or
2 mental) identified as a result of a pre-enrollment questionnaire or physical examination given to
3 the individual, or review of medical records relating to the pre-enrollment period.

4 (c) This section shall not apply to grandfathered health plans providing individual health
5 insurance coverage.

6 (d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
7 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
8 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
9 bodily injury or death by accident or both; and (9) Other limited benefit policies.

10 SECTION 5. Sections 27-19-1 and 27-19-50 of the General laws in Chapter 27-19
11 entitled "Nonprofit Hospital Service Corporations" are hereby amended to read as follows:

12 **27-19-1. Definitions. -- As used in this chapter:**

13 (1) "Contracting hospital" means an eligible hospital which has contracted with a
14 nonprofit hospital service corporation to render hospital care to subscribers to the nonprofit
15 hospital service plan operated by the corporation;

16 (2) "Adverse benefit determination" means any of the following: a denial, reduction, or
17 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,
18 including any such denial, reduction, termination, or failure to provide or make payment that is
19 based on a determination of an individual's eligibility to participate in a plan or to receive
20 coverage under a plan, and including, with respect to group health plans, a denial, reduction, or
21 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit
22 resulting from the application of any utilization review, as well as a failure to cover an item or
23 service for which benefits are otherwise provided because it is determined to be experimental or
24 investigational or not medically necessary or appropriate. The term also includes a rescission of
25 coverage determination.

26 (3) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act
27 of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and
28 federal regulations adopted thereunder;

29 (4) "Commissioner" or "health insurance commissioner" means that individual appointed
30 pursuant to section 42-14.5-1 of the General laws;

31 (5) "Eligible hospital" is one which is maintained either by the state or by any of its
32 political subdivisions or by a corporation organized for hospital purposes under the laws of this
33 state or of any other state or of the United States, which is designated as an eligible hospital by a
34 majority of the directors of the nonprofit hospital service corporation;

1 (6) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the
2 federal Affordable Care Act.

3 (7) "Grandfathered health plan" means any group health plan or health insurance
4 coverage subject to 42 USC section 18011;

5 (8) "Group health insurance coverage" means, in connection with a group health plan,
6 health insurance coverage offered in connection with such plan;

7 (9) "Group health plan" means an employee welfare benefit plan as defined 29 USC
8 section 1002(1), to the extent that the plan provides health benefits to employees or their
9 dependents directly or through insurance, reimbursement, or otherwise;

10 (10) "Health benefits" or "covered benefits" means coverage or benefits for the
11 diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose
12 of affecting any structure or function of the body including coverage or benefits for transportation
13 primarily for and essential thereto, and including medical services as defined in R.I. Gen. Laws §
14 27-19-17;

15 (11) "Health care facility" means an institution providing health care services or a health
16 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory
17 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,
18 laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

19 (12) "Health care professional" means a physician or other health care practitioner
20 licensed, accredited or certified to perform specified health care services consistent with state
21 law;

22 (13) "Health care provider" or "provider" means a health care professional or a health
23 care facility;

24 (14) "Health care services" means services for the diagnosis, prevention, treatment, cure
25 or relief of a health condition, illness, injury or disease;

26 (15) "Health insurance carrier" means a person, firm, corporation or other entity subject
27 to the jurisdiction of the commissioner under this chapter, and includes nonprofit hospital service
28 corporations. Such term does not include a group health plan. The use of this term shall not be
29 construed to subject a nonprofit hospital service corporation to the insurance laws of this state
30 other than as set forth in R.I. Gen. Laws § 27-19-2;

31 (16) "Health plan" or "health benefit plan" means health insurance coverage and a group
32 health plan, including coverage provided through an association plan if it covers Rhode Island
33 residents. Except to the extent specifically provided by the federal Affordable Care Act, the term
34 "health plan" shall not include a group health plan to the extent state regulation of the health plan

1 is pre-empted under section 514 of the federal Employee Retirement Income Security Act of
2 1974. The term also shall not include:

3 (A)(i) Coverage only for accident, or disability income insurance, or any combination
4 thereof.

5 (ii) Coverage issued as a supplement to liability insurance.

6 (iii) Liability insurance, including general liability insurance and automobile liability
7 insurance.

8 (iv) Workers' compensation or similar insurance.

9 (v) Automobile medical payment insurance.

10 (vi) Credit-only insurance.

11 (vii) Coverage for on-site medical clinics.

12 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant to
13 federal Pub. L. No. 104-191, the federal health insurance portability and accountability act of
14 1996 ("HIPAA"), under which benefits for medical care are secondary or incidental to other
15 insurance benefits.

16 (B) The following benefits if they are provided under a separate policy, certificate or
17 contract of insurance or are otherwise not an integral part of the plan:

18 (i) Limited scope dental or vision benefits.

19 (ii) Benefits for long-term care, nursing home care, home health care, community-based
20 care, or any combination thereof.

21 (iii) Other excepted benefits specified in federal regulations issued pursuant to federal
22 Pub. L. No. 104-191 ("HIPAA").

23 (C) The following benefits if the benefits are provided under a separate policy, certificate
24 or contract of insurance, there is no coordination between the provision of the benefits and any
25 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the
26 benefits are paid with respect to an event without regard to whether benefits are provided with
27 respect to such an event under any group health plan maintained by the same plan sponsor:

28 (i) Coverage only for a specified disease or illness.

29 (ii) Hospital indemnity or other fixed indemnity insurance.

30 (D) The following if offered as a separate policy, certificate or contract of insurance:

31 (i) Medicare supplement health insurance as defined under section 1882(g)(1) of the
32 federal Social Security Act.

33 (ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United
34 States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

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

2 (17) "Nonprofit hospital service corporation" means any corporation organized pursuant
3 to this chapter for the purpose of establishing, maintaining, and operating a nonprofit hospital
4 service plan;

5 (18) "Nonprofit hospital service plan" means a plan by which specified hospital care is to
6 be provided to subscribers to the plan by a contracting hospital;

7 (19) "Office of the health insurance commissioner" means the agency established under
8 section 42-14.5-1 of the General Law;

9 (20) "Rescission" means a cancellation or discontinuance of coverage that has retroactive
10 effect for reasons unrelated to timely payment of required premiums or contribution to costs of
11 coverage; and

12 (21) "Subscribers" mean those persons, whether or not residents of this state, who have
13 contracted with a nonprofit hospital service corporation for hospital care pursuant to a nonprofit
14 hospital service plan operated by the corporation.

15 **27-19-50. Termination of children's benefits Eligibility for children's benefits. --**

16 (a)(1) Every ~~individual health insurance contract, plan, or policy~~ health benefit plan delivered,
17 issued for delivery, or renewed in this state which provides ~~medical~~ health benefits coverage for
18 ~~dependent children that includes coverage for physician services in a physician's office, and~~
19 ~~every policy which provides major medical or similar comprehensive type coverage~~ dependents,
20 except for supplemental policies which only provide coverage for specified diseases and other
21 supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried child under the age~~
22 ~~of nineteen (19) years, an unmarried child who is a student under the age of twenty five (25)~~
23 ~~years and who is financially dependent upon the parent and an unmarried child of any age who is~~
24 ~~financially dependent upon the parent and medically determined to have a physical or mental~~
25 ~~impairment which can be expected to result in death or which has lasted or can be expected to last~~
26 ~~for a continuous period of not less than twelve (12) months~~ for children until attainment of
27 twenty-six (26) years of age, and an unmarried child of any age who is financially dependent
28 upon the parent and medically determined to have a physical or mental impairment which can be
29 expected to result in death or which has lasted or can be expected to last for a continuous period
30 of not less than twelve (12) months. ~~Such contract, plan or policy shall also include a provision~~
31 ~~that policyholders shall receive no less than thirty (30) days notice from the accident and sickness~~
32 ~~insurer that a child covered as a dependent by the policy holder is about to lose his or her~~
33 ~~coverage as a result of reaching the maximum age for a dependent child, and that the child will~~
34 ~~only continue to be covered upon documentation being provided of current full or part-time~~

1 ~~enrollment in a post-secondary educational institution or that the child may purchase a conversion~~
2 ~~policy if he or she is not an eligible student.~~

3 ~~(b) Nothing in this section prohibits a nonprofit hospital service corporation from~~
4 ~~requiring a policyholder to annually provide proof of a child's current full or part time enrollment~~
5 ~~in a post-secondary educational institution in order to maintain the child's coverage. Provided,~~
6 ~~nothing in this section requires coverage inconsistent with the membership criteria in effect under~~
7 ~~the policyholder's health benefits coverage.~~

8 (2) With respect to a child who has not attained twenty-six (26) years of age, a health
9 insurance carrier shall not define "dependent" for purposes of eligibility for dependent coverage
10 of children other than the terms of a relationship between a child and the plan participant or
11 subscriber.

12 (3) A health insurance carrier shall not deny or restrict coverage for a child who has not
13 attained twenty-six (26) years of age based on the presence or absence of the child's financial
14 dependency upon the participant, primary subscriber or any other person, residency with the
15 participant and in the individual market the primary subscriber, or with any other person, marital
16 status, student status, employment or any combination of those factors. A health carrier shall not
17 deny or restrict coverage of a child based on eligibility for other coverage, except as provided in
18 (b)(1) of this section.

19 (4) Nothing in this section shall be construed to require a health insurance carrier to make
20 coverage available for the child of a child receiving dependent coverage, unless the grandparent
21 becomes the legal guardian or adoptive parent of that grandchild.

22 (5) The terms of coverage in a health benefit plan offered by a health insurance carrier
23 providing dependent coverage of children cannot vary based on age except for children who are
24 twenty-six (26) years of age or older.

25 (b)(1) For plan years beginning before January 1, 2014, a group health plan providing
26 group health insurance coverage that is a grandfathered health plan and makes available
27 dependent coverage of children may exclude an adult child who has not attained twenty-six (26)
28 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-
29 sponsored health benefit plan, as defined in section 5000A(f)(2) of the federal Internal Revenue
30 Code, other than the group health plan of a parent.

31 (2) For plan years, beginning on or after January 1, 2014, a group health plan providing
32 group health insurance coverage that is a grandfathered health plan shall comply with the
33 requirements of this section.

34 (c) This section does not apply to insurance coverage providing benefits for: (1) Hospital

1 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
2 Medicare supplement; (6) Limited benefit health; (7) Specified diseased indemnity; or (8) Other
3 limited benefit policies.

4 SECTION 6. Chapter 27-19 of the General laws entitled "Nonprofit Hospital Service
5 Corporations" is hereby amended by adding thereto the following sections:

6 **27-19-7.1. Uniform explanation of benefits and coverage.** – (a) A nonprofit hospital
7 service corporation shall provide a summary of benefits and coverage explanation and definitions
8 to policyholders and others required by, and at the times and in the format required, by the federal
9 regulations adopted under section 2715 of the Public Health Service Act, as amended by the
10 federal Affordable Care Act. The forms required by this section shall be made available to the
11 commissioner on request. Nothing in this section shall be construed to limit the authority of the
12 commissioner under existing state law.

13 (b) The provisions of this section shall apply to grandfathered health plans. This section
14 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
15 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6)
16 Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by
17 accident or both; and (9) Other limited benefit policies.

18 (c) If the commissioner of the office of the health insurance commissioner determines
19 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
20 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
21 an act of Congress, on the date of the commissioner's determination this section shall have its
22 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
23 section. Nothing in this section shall be construed to limit the authority of the commissioner
24 under existing state law.

25 **27-19-7.2. Filing of policy forms.** – A nonprofit hospital service corporation shall file all
26 policy forms and rates used by it in the state with the commissioner, including the forms of any
27 rider, endorsement, application blank, and other matter generally used or incorporated by
28 reference in its policies or contracts of insurance. No such form shall be used if disapproved by
29 the commissioner under this section, or if the commissioner's approval has been withdrawn after
30 notice and an opportunity to be heard, or until the expiration of sixty (60) days following the
31 filing of the form. Such a company shall comply with its filed and approved forms. If the
32 commissioner finds from an examination of any form that it is contrary to the public interest, or
33 the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and
34 shall notify the corporation in writing.

1 (b) Each rate filing shall include a certification by a qualified actuary that to the best of
2 the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws
3 and that the benefits offered or proposed to be offered are reasonable in relation to the premium
4 to be charged. A health insurance carrier shall comply with its filed and approved rates and
5 forms.

6 **27-19-62. Prohibition on rescission of coverage.** – (a)(1) Coverage under a health plan
7 subject to the jurisdiction of the commissioner under this chapter with respect to an individual,
8 including a group to which the individual belongs or family coverage in which the individual is
9 included, shall not be rescinded after the individual is covered under the plan, unless:

10 (A) The individual or a person seeking coverage on behalf of the individual, performs an
11 act, practice or omission that constitutes fraud; or

12 (B) The individual makes an intentional misrepresentation of material fact, as prohibited
13 by the terms of the plan or coverage.

14 (2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an
15 individual does not include an insurance producer or employee or authorized representative of the
16 health carrier.

17 (b) At least thirty (30) days advance written notice shall be provided to each health
18 benefit plan enrollee or, for individual health insurance coverage, primary subscriber, who would
19 be affected by the proposed rescission of coverage before coverage under the plan may be
20 rescinded in accordance with subsection (a) regardless of, in the case of group health insurance
21 coverage, whether the rescission applies to the entire group or only to an individual within the
22 group.

23 (c) For purposes of this section, “to rescind” means to cancel or to discontinue coverage
24 with retroactive effect for reasons unrelated to timely payment of required premiums or
25 contribution to costs of coverage.

26 (d) This section applies to grandfathered health plans.

27 **27-19-63. Prohibition on annual and lifetime limits.** – (a) Annual limits. (1) For plan or
28 policy years beginning prior to January 1, 2014, for any individual, a health insurance carrier and
29 health benefit plan subject to the jurisdiction of the commissioner under this chapter may
30 establish an annual limit on the dollar amount of benefits that are essential health benefits
31 provided the restricted annual limit is not less than the following:

32 (A) For a plan or policy year beginning after September 22, 2011, but before September
33 23, 2012 – one million two hundred fifty thousand dollars (\$1,250,000); and

34 (B) For a plan or policy year beginning after September 22, 2012, but before January 1,

1 2014 – two million dollars (\$2,000,000).

2 (2) For plan or policy years beginning on or after January 1, 2014, a health insurance
3 carrier and health benefit plan shall not establish any annual limit on the dollar amount of
4 essential health benefits for any individual, except:

5 (A) A health flexible spending arrangement, as defined in Section 106(c)(2)(i) of the
6 federal Internal Revenue Code, a medical savings account, as defined in Section 220 of the
7 federal Internal Revenue Code, and a health savings account, as defined in Section 223 of the
8 federal Internal Revenue Code, are not subject to the requirements of subdivisions (1) and (2) of
9 this subsection.

10 (B) The provisions of this subsection shall not prevent a health insurance carrier and
11 health benefit plan from placing annual dollar limits for any individual on specific covered
12 benefits that are not essential health benefits to the extent that such limits are otherwise permitted
13 under applicable federal law or the laws and regulations of this state.

14 (3) In determining whether an individual has received benefits that meet or exceed the
15 allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier and
16 health benefit plan shall take into account only essential health benefits.

17 (b) Lifetime limits.

18 (1) A health insurance carrier and health benefit plan offering group or individual health
19 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
20 benefits for any individual.

21 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
22 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
23 benefits that are not essential health benefits in accordance with federal laws and regulations.

24 (c)(1) The provisions of this section relating to lifetime limits apply to any health
25 insurance carrier providing coverage under an individual or group health plan, including
26 grandfathered health plans.

27 (2) The provisions of this section relating to annual limits apply to any health insurance
28 carrier providing coverage under a group health plan, including grandfathered health plans, but
29 the prohibition and limits on annual limits do not apply to grandfathered health plans providing
30 individual health insurance coverage.

31 (d) This section shall not apply to a plan or to policy years prior to January 1, 2014 for
32 which the Secretary of the U.S. Department of Health and Human Services issued a waiver
33 pursuant to 45 C.F.R. § 147.126(d)(3) This section also shall not apply to insurance coverage
34 providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident

1 only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified
2 disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other
3 limited benefit policies.

4 (e) If the commissioner of the office of the health insurance commissioner determines
5 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
6 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
7 an act of Congress, on the date of the commissioner's determination this section shall have its
8 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
9 section. Nothing in this subsection shall be construed to limit the authority of the Commissioner
10 to regulate health insurance under existing state law.

11 **27-19-64. Coverage for individuals participating in approved clinical trials. – (a) As**
12 **used in this section:**

13 (1) “Approved clinical trial” means a phase I, phase II, phase III or phase IV clinical trial
14 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
15 threatening disease or condition and is described in any of the following:

16 (A) The study or investigation is approved or funded, which may include funding through
17 in-kind contributions, by one or more of the following:

18 (i) The federal National Institutes of Health;

19 (ii) The federal Centers for Disease Control and Prevention;

20 (iii) The federal Agency for Health Care Research and Quality;

21 (iv) The federal Centers for Medicare & Medicaid Services;

22 (v) A cooperative group or center of any of the entities described in items (i) through (iv)
23 or the U.S. Department of Defense or the U.S. Department of Veterans' Affairs;

24 (vi) A qualified non-governmental research entity identified in the guidelines issued by
25 the federal National Institutes of Health for center support grants; or

26 (vii) A study or investigation conducted by the U.S. Department of Veterans' Affairs, the
27 U.S. Department of Defense, or the U.S. Department of Energy, if the study or
28 investigation has been reviewed and approved through a system of peer review that the Secretary
29 of U.S. Department of Health and Human Services determines:

30 (I) Is comparable to the system of peer review of studies and investigations used by the
31 Federal National Institutes of Health; and

32 (II) Assures unbiased review of the highest scientific standards by qualified individuals
33 who have no interest in the outcome of the review.

34 (B) The study or investigation is conducted under an investigational new drug application

1 reviewed by the U.S. Food and Drug Administration; or

2 (C) The study or investigation is a drug trial that is exempt from having such an
3 investigational new drug application.

4 (2) “Participant” has the meaning stated in section 3(7) of federal ERISA.

5 (3) “Participating provider” means a health care provider that, under a contract with the
6 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
7 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
8 deductibles, directly or indirectly from the health carrier.

9 (4) “Qualified individual” means a participant or beneficiary who meets the following
10 conditions:

11 (A) The individual is eligible to participate in an approved clinical trial according to the
12 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;
13 and

14 (B)(i) The referring health care professional is a participating provider and has concluded
15 that the individual’s participation in such trial would be appropriate based on the individual
16 meeting the conditions described in subdivision (A) of this subdivision (3); or

17 (ii) The participant or beneficiary provides medical and scientific information
18 establishing the individual’s participation in such trial would be appropriate based on the
19 individual meeting the conditions described in subdivision (A) of this subdivision (3).

20 (5) “Life-threatening condition” means any disease or condition from which the
21 likelihood of death is probable unless the course of the disease or condition is interrupted.

22 (b)(1) If a health insurance carrier offering group or individual health insurance coverage
23 provides coverage to a qualified individual, the health carrier:

24 (A) Shall not deny the individual participation in an approved clinical trial.

25 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose
26 additional conditions on the coverage of routine patient costs for items and services furnished in
27 connection with participation in the approved clinical trial; and

28 (C) Shall not discriminate against the individual on the basis of the individual’s
29 participation in the approved clinical trial.

30 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all
31 items and services consistent with the coverage typically covered for a qualified individual who is
32 not enrolled in an approved clinical trial.

33 (B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not
34 include:

1 (i) The investigational item, device or service itself;
2 (ii) Items and services that are provided solely to satisfy data collection and analysis
3 needs and that are not used in the direct clinical management of the patient; or
4 (iii) A service that is clearly inconsistent with widely accepted and established standards
5 of care for a particular diagnosis.
6 (3) If one or more participating providers are participating in a clinical trial, nothing in
7 subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring
8 that a qualified individual participate in the trial through such a participating provider if the
9 provider will accept the individual as a participant in the trial.
10 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection
11 shall apply to a qualified individual participating in an approved clinical trial that is conducted
12 outside this state.
13 (5) This section shall not be construed to require a health carrier offering group or
14 individual health insurance coverage to provide benefits for routine patient care services provided
15 outside of the coverage's health care provider network unless out-of-network benefits are
16 otherwise provided under the coverage.
17 (6) Nothing in this section shall be construed to limit a health carrier's coverage with
18 respect to clinical trials.
19 (c) The requirements of this section shall be in addition to the requirements of Rhode
20 Island general laws sections 27-18-32 through 27-19-32.2.
21 (d) The provisions of this section shall apply to grandfathered health plans. This section
22 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
23 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6)
24 Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by
25 accident or both; and (9) Other limited benefit policies.
26 (e) This section shall be effective for plan years beginning on or after January 1, 2014.
27 **27-19-65. Medical loss ratio reporting and rebates.** – (a) A nonprofit hospital service
28 corporation offering group or individual health insurance coverage of a health benefit plan,
29 including a grandfathered health plan, shall comply with the provisions of Section 2718 of the
30 Public Health Services Act as amended by the federal Affordable Care Act, in accordance with
31 regulations adopted thereunder.
32 (b) Health insurance carriers required to report medical loss ratio and rebate calculations
33 and other medical loss ratio and rebate information to the U.S. Department of Health and Human
34 Services shall concurrently file such information with the commissioner.

1 **27-19-66. Emergency services. – (a) As used in this section:**

2 (1) “Emergency medical condition” means a medical condition manifesting itself by
3 acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
4 possesses an average knowledge of health and medicine, could reasonably expect the absence of
5 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
6 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
7 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
8 part.

9 (2) “Emergency services” means, with respect to an emergency medical condition:

10 (A) A medical screening examination (as required under section 1867 of the Social
11 Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a
12 hospital, including ancillary services routinely available to the emergency department to evaluate
13 such emergency medical condition, and

14 (B) Such further medical examination and treatment, to the extent they are within the
15 capabilities of the staff and facilities available at the hospital, as are required under section 1867
16 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

17 (3) “Stabilize”, with respect to an emergency medical condition has the meaning given in
18 section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

19 (b) If a nonprofit hospital service corporation provides any benefits to subscribers with
20 respect to services in an emergency department of a hospital, the plan must cover emergency
21 services consistent with the rules of this section.

22 (c) A nonprofit hospital service corporation shall provide coverage for emergency
23 services in the following manner:

24 (1) Without the need for any prior authorization determination, even if the emergency
25 services are provided on an out-of-network basis;

26 (2) Without regard to whether the health care provider furnishing the emergency services
27 is a participating network provider with respect to the services;

28 (3) If the emergency services are provided out of network, without imposing any
29 administrative requirement or limitation on coverage that is more restrictive than the requirements
30 or limitations that apply to emergency services received from in-network providers;

31 (4) If the emergency services are provided out of network, by complying with the cost-
32 sharing requirements of subsection (d) of this section; and

33 (5) Without regard to any other term or condition of the coverage, other than:

34 (A) The exclusion of or coordination of benefits;

1 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
2 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

3 (C) Applicable cost sharing.

4 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
5 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
6 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
7 the services were provided in-network. However, a participant or beneficiary may be required to
8 pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network
9 provider charges over the amount the plan or health insurance carrier is required to pay under
10 subdivision (1) of this subsection. A group health plan or health insurance carrier complies with
11 the requirements of this subsection if it provides benefits with respect to an emergency service in
12 an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
13 this subdivision (1)(which are adjusted for in-network cost-sharing requirements).

14 (A) The amount negotiated with in-network providers for the emergency service
15 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
16 participant or beneficiary. If there is more than one amount negotiated with in-network providers
17 for the emergency service, the amount described under this subdivision (A) is the median of these
18 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
19 participant or beneficiary. In determining the median described in the preceding sentence, the
20 amount negotiated with each in-network provider is treated as a separate amount (even if the
21 same amount is paid to more than one provider). If there is no per-service amount negotiated with
22 in-network providers (such as under a capitation or other similar payment arrangement), the
23 amount under this subdivision (A) is disregarded.

24 (B) The amount for the emergency service shall be calculated using the same method the
25 plan generally uses to determine payments for out-of-network services (such as the usual,
26 customary, and reasonable amount), excluding any in-network copayment or coinsurance
27 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
28 determined without reduction for out-of-network cost sharing that generally applies under the
29 plan or health insurance coverage with respect to out-of-network services. Thus, for example, if a
30 plan generally pays seventy percent (70%) of the usual, customary, and reasonable amount for
31 out-of-network services, the amount in this subdivision (B) for an emergency service is the total,
32 that is, one hundred percent (100%), of the usual, customary, and reasonable amount for the
33 service, not reduced by the thirty percent (30%) coinsurance that would generally apply to out-of-
34 network services (but reduced by the in-network copayment or coinsurance that the individual

1 would be responsible for if the emergency service had been provided in-network).

2 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
3 Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network
4 copayment or coinsurance imposed with respect to the participant or beneficiary.

5 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
6 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
7 services provided out of network if the cost-sharing requirement generally applies to out-of-
8 network benefits. A deductible may be imposed with respect to out-of-network emergency
9 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
10 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
11 apply to out-of-network emergency services.

12 (e) The provisions of this section apply for plan years beginning on or after September
13 23, 2010.

14 (f) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
15 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
16 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
17 bodily injury or death by accident or both; and (9) Other limited benefit policies.

18 **27-19-67. Internal and external appeal of adverse benefit determinations.** – (a) The
19 commissioner shall adopt regulations to implement standards and procedures with respect to
20 internal claims and appeals of adverse benefit determinations, and with respect to external appeals
21 of adverse benefit determinations.

22 (b) The regulations adopted by the commissioner shall apply only to those adverse
23 benefit determinations which are not subject to the jurisdiction of the department of health
24 pursuant to R.I. Gen. Laws § 23-17.12 et seq. (Utilization Review Act).

25 (c) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
26 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
27 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
28 bodily injury or death by accident or both; and (9) Other limited benefit policies. This section also
29 shall not apply to grandfathered health plans.

30 **27-19-68. Prohibition on preexisting condition exclusions.** -- (a) A health insurance
31 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a
32 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

33 (1) Shall not limit or exclude coverage for an individual under the age of nineteen (19) by
34 imposing a preexisting condition exclusion on that individual.

1 (2) For plan or policy years beginning on or after January 1, 2014, shall not limit or
2 exclude coverage for any individual by imposing a preexisting condition exclusion on that
3 individual.

4 (b) As used in this section:

5 (1) "Preexisting condition exclusion" means a limitation or exclusion of benefits,
6 including a denial of coverage, based on the fact that the condition (whether physical or mental)
7 was present before the effective date of coverage, or if the coverage is denied, the date of denial,
8 under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was
9 recommended or received before the effective date of coverage.

10 (2) "Preexisting condition exclusion" means any limitation or exclusion of benefits,
11 including a denial of coverage, applicable to an individual as a result of information relating to an
12 individual's health status before the individual's effective date of coverage, or if the coverage is
13 denied, the date of denial, under the health benefit plan, such as a condition (whether physical or
14 mental) identified as a result of a pre-enrollment questionnaire or physical examination given to
15 the individual, or review of medical records relating to the pre-enrollment period.

16 (c) This section shall not apply to grandfathered health plans providing individual health
17 insurance coverage.

18 (d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
19 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
20 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
21 bodily injury or death by accident or both; and (9) Other limited benefit policies.

22 SECTION 7. Sections 27-20-1 and 27-20-45 of the General laws in Chapter 27-20
23 entitled "Nonprofit Medical Service Corporations" are hereby amended to read as follows:

24 **27-20-1. Definitions.** -- As used in this chapter:

25 (1) "Adverse benefit determination" means any of the following: a denial, reduction, or
26 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,
27 including any such denial, reduction, termination, or failure to provide or make payment that is
28 based on a determination of a an individual's eligibility to participate in a plan or to receive
29 coverage under a plan, and including, with respect to group health plans, a denial, reduction, or
30 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit
31 resulting from the application of any utilization review, as well as a failure to cover an item or
32 service for which benefits are otherwise provided because it is determined to be experimental or
33 investigational or not medically necessary or appropriate. The term also includes a rescission of
34 coverage determination.

1 (2) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act
2 of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and
3 federal regulations adopted thereunder;

4 ~~(3)~~ "Certified registered nurse practitioners" is an expanded role utilizing independent
5 knowledge of physical assessment and management of health care and illnesses. The practice
6 includes collaboration with other licensed health care professionals including, but not limited to,
7 physicians, pharmacists, podiatrists, dentists, and nurses;

8 (4) "Commissioner" or "health insurance commissioner" means that individual appointed
9 pursuant to section 42-14.5-1 of the General laws.

10 ~~(5)~~ "Counselor in mental health" means a person who has been licensed pursuant to
11 section 5-63.2-9.

12 (6) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the
13 federal Affordable Care Act.

14 (7) "Grandfathered health plan" means any group health plan or health insurance
15 coverage subject to 42 USC section 18011.

16 ~~(8)~~ "Group health insurance coverage" means, in connection with a group health plan,
17 health insurance coverage offered in connection with such plan.

18 (9) "Group health plan" means an employee welfare benefit plan as defined in 29 USC
19 section 1002(1) to the extent that the plan provides health benefits to employees or their
20 dependents directly or through insurance, reimbursement, or otherwise.

21 (10) "Health benefits" or "covered benefits" means coverage or benefits for the
22 diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose
23 of affecting any structure or function of the body including coverage or benefits for transportation
24 primarily for and essential thereto, and including medical services as defined in R.I. Gen. Laws §
25 27-19-17;

26 (11) "Health care facility" means an institution providing health care services or a health
27 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory
28 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,
29 laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

30 (12) "Health care professional" means a physician or other health care practitioner
31 licensed, accredited or certified to perform specified health care services consistent with state
32 law.

33 (13) "Health care provider" or "provider" means a health care professional or a health
34 care facility.

1 (14) "Health care services" means services for the diagnosis, prevention, treatment, cure
2 or relief of a health condition, illness, injury or disease.

3 (15) "Health insurance carrier" means a person, firm, corporation or other entity subject
4 to the jurisdiction of the commissioner under this chapter, and includes a nonprofit medical
5 service corporation. Such term does not include a group health plan.

6 (16) "Health plan" or "health benefit plan" means health insurance coverage and a group
7 health plan, including coverage provided through an association plan if it covers Rhode Island
8 residents. Except to the extent specifically provided by the federal Affordable Care Act, the term
9 "health plan" shall not include a group health plan to the extent state regulation of the health
10 plan is pre-empted under section 514 of the federal Employee Retirement Income Security Act of
11 1974. The term also shall not include:

12 (A)(i) Coverage only for accident, or disability income insurance, or any combination
13 thereof.

14 (ii) Coverage issued as a supplement to liability insurance.

15 (iii) Liability insurance, including general liability insurance and automobile liability
16 insurance.

17 (iv) Workers' compensation or similar insurance.

18 (v) Automobile medical payment insurance.

19 (vi) Credit-only insurance.

20 (vii) Coverage for on-site medical clinics.

21 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant to
22 Federal Pub. L. No. 104-191, the federal health insurance portability and accountability act of
23 1996 ("HIPAA"), under which benefits for medical care are secondary or incidental to other
24 insurance benefits.

25 (B) The following benefits if they are provided under a separate policy, certificate or
26 contract of insurance or are otherwise not an integral part of the plan:

27 (i) Limited scope dental or vision benefits.

28 (ii) Benefits for long-term care, nursing home care, home health care, community-based
29 care, or any combination thereof.

30 (iii) Other excepted benefits specified in federal regulations issued pursuant to federal
31 Pub. L. No. 104-191 ("HIPAA").

32 (C) The following benefits if the benefits are provided under a separate policy, certificate
33 or contract of insurance, there is no coordination between the provision of the benefits and any
34 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the

1 [benefits are paid with respect to an event without regard to whether benefits are provided with](#)
2 [respect to such an event under any group health plan maintained by the same plan sponsor:](#)

3 [\(i\) Coverage only for a specified disease or illness.](#)

4 [\(ii\) Hospital indemnity or other fixed indemnity insurance.](#)

5 [\(D\) The following if offered as a separate policy, certificate or contract of insurance:](#)

6 [\(i\) Medicare supplement health insurance as defined under section 1882\(g\)\(1\) of the](#)
7 [federal Social Security Act.](#)

8 [\(ii\) Coverage supplemental to the coverage provided under chapter 55 of title 10, United](#)
9 [States Code \(Civilian Health and Medical Program of the Uniformed Services \(CHAMPUS\)\).](#)

10 [\(iii\) Similar supplemental coverage provided to coverage under a group health plan.](#)

11 ~~(3)~~[\(17\)](#) "Licensed midwife" means any midwife licensed under section 23-13-9;

12 ~~(4)~~[\(18\)](#) "Medical services" means those professional services rendered by persons duly
13 licensed under the laws of this state to practice medicine, surgery, chiropractic, podiatry, and
14 other professional services rendered by a licensed midwife, certified registered nurse
15 practitioners, and psychiatric and mental health nurse clinical specialists, and appliances, drugs,
16 medicines, supplies, and nursing care necessary in connection with the services, or the expense
17 indemnity for the services, appliances, drugs, medicines, supplies, and care, as may be specified
18 in any nonprofit medical service plan. Medical service shall not be construed to include hospital
19 services;

20 ~~(5)~~[\(19\)](#) "Nonprofit medical service corporation" means any corporation organized
21 pursuant hereto for the purpose of establishing, maintaining, and operating a nonprofit medical
22 service plan;

23 ~~(6)~~[\(20\)](#) "Nonprofit medical service plan" means a plan by which specified medical
24 service is provided to subscribers to the plan by a nonprofit medical service corporation;

25 [\(21\) "Office of the health insurance commissioner" means the agency established under](#)
26 [section 42-14.5-1 of the General laws.](#)

27 ~~(7)~~[\(22\)](#) "Psychiatric and mental health nurse clinical specialist" is an expanded role
28 utilizing independent knowledge and management of mental health and illnesses. The practice
29 includes collaboration with other licensed health care professionals, including, but not limited to,
30 psychiatrists, psychologists, physicians, pharmacists, and nurses;

31 [\(23\) "Rescission" means a cancellation or discontinuance of coverage that has retroactive](#)
32 [effect for reasons unrelated to timely payment of required premiums or contribution to costs of](#)
33 [coverage.](#)

34 ~~(8)~~[\(24\)](#) "Subscribers" means those persons or groups of persons who contract with a

1 nonprofit medical service corporation for medical service pursuant to a nonprofit medical service
2 plan; and

3 ~~(9)~~(25) "Therapist in marriage and family practice" means a person who has been
4 licensed pursuant to section 5-63.2-10.

5 ~~27-20-45. Termination of children's benefits~~ Eligibility for children's benefits. --

6 (a)(1) Every ~~individual health insurance contract, plan, or policy~~ health benefit plan delivered,
7 issued for delivery, or renewed in this state ~~and every group health insurance contract, plan, or~~
8 ~~policy delivered, issued for delivery or renewed in this state~~ which provides medical health
9 benefits coverage for ~~dependent children that includes coverage for physician services in a~~
10 ~~physician's office, and every policy which provides major medical or similar comprehensive type~~
11 ~~coverage~~ dependents, except for supplemental policies which only provide coverage for specified
12 diseases and other supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried~~
13 ~~child under the age of nineteen (19) years, an unmarried child who is a student under the age of~~
14 ~~twenty five (25) years and who is financially dependent upon the parent and an unmarried child~~
15 ~~of any age who is financially dependent upon the parent and medically determined to have a~~
16 ~~physical or mental impairment which can be expected to result in death or which has lasted or can~~
17 ~~be expected to last for a continuous period of not less than twelve (12) months~~ for children until
18 attainment of twenty-six (26) years of age, and an unmarried child of any age who is financially
19 dependent upon the parent and medically determined to have a physical or mental impairment
20 which can be expected to result in death or which has lasted or can be expected to last for a
21 continuous period of not less than twelve (12) months. ~~Such contract, plan or policy shall also~~
22 ~~include a provision that policyholders shall receive no less than thirty (30) days notice from the~~
23 ~~accident and sickness insurer that a child covered as a dependent by the policy holder is about to~~
24 ~~lose his or her coverage as a result of reaching the maximum age for a dependent child, and that~~
25 ~~the child will only continue to be covered upon documentation being provided of current full or~~
26 ~~part time enrollment in a post secondary educational institution or that the child may purchase a~~
27 ~~conversion policy if he or she is not an eligible student.~~

28 ~~(b) Nothing in this section prohibits a nonprofit medical service corporation from~~
29 ~~requiring a policyholder to annually provide proof of a child's current full or part time enrollment~~
30 ~~in a post secondary educational institution in order to maintain the child's coverage.~~

31 (2) With respect to a child who has not attained twenty-six (26) years of age, a nonprofit
32 medical service corporation shall not define "dependent" for purposes of eligibility for dependent
33 coverage of children other than the terms of a relationship between a child and the plan
34 participant or subscriber.

1 (3) A nonprofit medical service corporation shall not deny or restrict coverage for a child
2 who has not attained twenty-six (26) years of age based on the presence or absence of the child's
3 financial dependency upon the participant, primary subscriber or any other person, residency with
4 the participant and in the individual market the primary subscriber, or with any other person,
5 marital status, student status, employment or any combination of those factors. A nonprofit
6 medical service corporation shall not deny or restrict coverage of a child based on eligibility for
7 other coverage, except as provided in (b)(1) of this section.

8 (4) Nothing in this section shall be construed to require a health insurance carrier to make
9 coverage available for the child of a child receiving dependent coverage, unless the grandparent
10 becomes the legal guardian or adoptive parent of that grandchild.

11 (5) The terms of coverage in a health benefit plan offered by a nonprofit medical service
12 corporation or providing dependent coverage of children cannot vary based on age except for
13 children who are twenty-six (26) years of age or older.

14 (b)(1) For plan years beginning before January 1, 2014, a group health plan providing
15 group health insurance coverage that is a grandfathered health plan and makes available
16 dependent coverage of children may exclude an adult child who has not attained twenty-six (26)
17 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-
18 sponsored health benefit plan, as defined in section 5000A(f)(2) of the federal Internal Revenue
19 Code, other than the group health plan of a parent.

20 (2) For plan years, beginning on or after January 1, 2014, a health insurance carrier
21 providing group health insurance coverage that is a grandfathered health plan shall comply with
22 the requirements of this section.

23 (c)This section does not apply to insurance coverage providing benefits for: (1) hospital
24 confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare
25 supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other limited
26 benefit policies.

27 SECTION 8. Chapter 27-20 of the General laws entitled "Nonprofit Medical Service
28 Corporations" is hereby amended by adding thereto the following sections:

29 **27-20-6.1. Uniform explanation of benefits and coverage.** – (a) A nonprofit medical
30 service corporation shall provide a summary of benefits and coverage explanation and definitions
31 to policyholders and others required by, and at the times and in the format required, by the federal
32 regulations adopted under section 2715 of the Public Health Service Act, as amended by the
33 federal Affordable Care Act. The forms required by this section shall be made available to the
34 commissioner on request. Nothing in this section shall be construed to limit the authority of the

1 commissioner under existing state law.

2 (b) The provisions of this section shall apply to grandfathered health plans. This section
3 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
4 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6)
5 Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by
6 accident or both; and (9) Other limited benefit policies.

7 (c) If the commissioner of the office of the health insurance commissioner determines
8 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
9 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
10 an act of Congress, on the date of the commissioner's determination this section shall have its
11 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
12 section. Nothing in this section shall be construed to limit the authority of the commissioner
13 under existing state law.

14 **27-20-6.2. Filing of policy forms.** – (a) A nonprofit medical service corporation shall file
15 all policy forms and rates used by it in the state with the commissioner, including the forms of
16 any rider, endorsement, application blank, and other matter generally used or incorporated by
17 reference in its policies or contracts of insurance. No such form shall be used if disapproved by
18 the commissioner under this section, or if the commissioner's approval has been withdrawn after
19 notice and an opportunity to be heard, or until the expiration of sixty (60) days following the
20 filing of the form. Such a company shall comply with its filed and approved forms. If the
21 commissioner finds from an examination of any form that it is contrary to the public interest, or
22 the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and
23 shall notify the corporation in writing.

24 (b) Each rate filing shall include a certification by a qualified actuary that to the best of
25 the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws
26 and that the benefits offered or proposed to be offered are reasonable in relation to the premium
27 to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

28
29 **27-20-57. Prohibition on preexisting condition exclusions.** -- (a) A health insurance
30 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a
31 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

32 (1) Shall not limit or exclude coverage for an individual under the age of nineteen (19) by
33 imposing a preexisting condition exclusion on that individual.

34 (2) For plan or policy years beginning on or after January 1, 2014, shall not limit or

1 exclude coverage for any individual by imposing a preexisting condition exclusion on that
2 individual.

3 (b) As used in this section:

4 (1) “Preexisting condition exclusion” means a limitation or exclusion of benefits,
5 including a denial of coverage, based on the fact that the condition (whether physical or mental)
6 was present before the effective date of coverage, or if the coverage is denied, the date of denial,
7 under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was
8 recommended or received before the effective date of coverage.

9 (2) “Preexisting condition exclusion” means any limitation or exclusion of benefits,
10 including a denial of coverage, applicable to an individual as a result of information relating to an
11 individual’s health status before the individual’s effective date of coverage, or if the coverage is
12 denied, the date of denial, under the health benefit plan, such as a condition (whether physical or
13 mental) identified as a result of a pre-enrollment questionnaire or physical examination given to
14 the individual, or review of medical records relating to the pre-enrollment period.

15 (c) This section shall not apply to grandfathered health plans providing individual health
16 insurance coverage.

17 (d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
18 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
19 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
20 bodily injury or death by accident or both; and (9) Other limited benefit policies.

21 **27-20-58. Prohibition on rescission of coverage.** – (a)(1) Coverage under a health
22 benefit plan subject to the jurisdiction of the commissioner under this chapter with respect to an
23 individual, including a group to which the individual belongs or family coverage in which the
24 individual is included, shall not be subject to rescission after the individual is covered under the
25 plan, unless:

26 (A)The individual or a person seeking coverage on behalf of the individual, performs an
27 act, practice or omission that constitutes fraud; or

28 (B)The individual makes an intentional misrepresentation of material fact, as prohibited
29 by the terms of the plan or coverage.

30 (2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an
31 individual does not include an insurance producer or employee or authorized representative of the
32 health carrier.

33 (b) At least thirty (30) days advance written notice shall be provided to each plan enrollee
34 or, for individual health insurance coverage, primary subscriber, who would be affected by the

1 proposed rescission of coverage before coverage under the plan may be rescinded in accordance
2 with subsection (a) regardless of, in the case of group health insurance coverage, whether the
3 rescission applies to the entire group or only to an individual within the group.

4 (c) This section applies to grandfathered health plans.

5 **27-20-59. Annual and lifetime limits. – (a) Annual limits.**

6 (1) For plan or policy years beginning prior to January 1, 2014, for any individual, a
7 health insurance carrier and health benefit plan subject to the jurisdiction of the commissioner
8 under this chapter may establish an annual limit on the dollar amount of benefits that are essential
9 health benefits provided the restricted annual limit is not less than the following:

10 (A) For a plan or policy year beginning after September 22, 2011, but before September
11 23, 2012 – one million two hundred fifty thousand dollars (\$1,250,000); and

12 (B) For a plan or policy year beginning after September 22, 2012, but before January 1,
13 2014 – two million dollars (\$2,000,000).

14 (2) For plan or policy years beginning on or after January 1, 2014, a health insurance
15 carrier and health benefit plan shall not establish any annual limit on the dollar amount of
16 essential health benefits for any individual, except:

17 (A) A health flexible spending arrangement, as defined in section 106(c)(2)(i) of the
18 federal Internal Revenue Code, a medical savings account, as defined in section 220 of the federal
19 Internal Revenue Code, and a health savings account, as defined in section 223 of the federal
20 Internal Revenue Code are not subject to the requirements of subdivisions (1) and (2) of this
21 subsection.

22 (B) The provisions of this subsection shall not prevent a health insurance carrier from
23 placing annual dollar limits for any individual on specific covered benefits that are not essential
24 health benefits to the extent that such limits are otherwise permitted under applicable federal law
25 or the laws and regulations of this state.

26 (3) In determining whether an individual has received benefits that meet or exceed the
27 allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier shall
28 take into account only essential health benefits.

29 (b) Lifetime limits.

30 (1) A health insurance carrier and health benefit plan offering group or individual health
31 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
32 benefits for any individual.

33 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
34 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered

1 benefits that are not essential health benefits, as designated pursuant to a state determination and
2 in accordance with federal laws and regulations.

3 (c)(1) Except as provided in subdivision (2) of this subsection, this section applies to any
4 health insurance carrier providing coverage under an individual or group health plan.

5 (2)(A) The prohibition on lifetime limits applies to grandfathered health plans.

6 (B) The prohibition and limits on annual limits apply to grandfathered health plans
7 providing group health insurance coverage, but the prohibition and limits on annual limits do not
8 apply to grandfathered health plans providing individual health insurance coverage.

9 (d) This section shall not apply to a plan or to policy years prior to January 1, 2014 for
10 which the Secretary of the U.S. Department of Health and Human Services issued a waiver
11 pursuant to 45 C.F.R. §147.126(d)(3). This section also shall not apply to insurance coverage
12 providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident
13 only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified
14 disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other
15 limited benefit policies.

16 (e) If the commissioner of the office of the health insurance commissioner determines
17 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
18 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
19 an act of Congress, on the date of the commissioner's determination this section shall have its
20 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
21 section. Nothing in this subsection shall be construed to limit the authority of the Commissioner
22 to regulate health insurance under existing state law.

23 **27-20-60. Coverage for individuals participating in approved clinical trials. – (a) As**
24 **used in this section,**

25 (1) “Approved clinical trial” means a phase I, phase II, phase III or phase IV clinical trial
26 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
27 threatening disease or condition and is described in any of the following:

28 (A) The study or investigation is approved or funded, which may include funding through
29 in-kind contributions, by one or more of the following:

30 (i) The federal National Institutes of Health;

31 (ii) The federal Centers for Disease Control and Prevention;

32 (iii) The federal Agency for Health Care Research and Quality;

33 (iv) The federal Centers for Medicare & Medicaid Services;

34 (v) A cooperative group or center of any of the entities described in items (i) through (iv)

1 or the U.S. Department of Defense or the U.S. Department of Veteran Affairs;
2 (vi) A qualified non-governmental research entity identified in the guidelines issued by
3 the federal National Institutes of Health for center support grants; or
4 (vii) A study or investigation conducted by the U.S. Department of Veteran Affairs, the
5 U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has
6 been reviewed and approved through a system of peer review that the Secretary of U.S.
7 Department of Health and Human Services determines:
8 (I) Is comparable to the system of peer review of studies and investigations used by the
9 federal National Institutes of Health; and
10 (II) Assures unbiased review of the highest scientific standards by qualified individuals
11 who have no interest in the outcome of the review.
12 (B) The study or investigation is conducted under an investigational new drug application
13 reviewed by the U.S. Food and Drug Administration; or
14 (C) The study or investigation is a drug trial that is exempt from having such an
15 investigational new drug application.
16 (2) “Participant” has the meaning stated in section 3(7) of federal ERISA.
17 (3) “Participating provider” means a health care provider that, under a contract with the
18 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
19 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
20 deductibles, directly or indirectly from the health carrier.
21 (4) “Qualified individual” means a participant or beneficiary who meets the following
22 conditions:
23 (A) The individual is eligible to participate in an approved clinical trial according to the
24 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;
25 and
26 (B)(i) The referring health care professional is a participating provider and has concluded
27 that the individual’s participation in such trial would be appropriate based on the individual
28 meeting the conditions described in subdivision (A) of this subdivision (3); or
29 (ii) The participant or beneficiary provides medical and scientific information
30 establishing the individual’s participation in such trial would be appropriate based on the
31 individual meeting the conditions described in subdivision (A) of this subdivision (3).
32 (5) “Life-threatening condition” means any disease or condition from which the
33 likelihood of death is probable unless the course of the disease or condition is interrupted.
34 (b)(1) If a health insurance carrier offering group or individual health insurance coverage

1 provides coverage to a qualified individual, the health carrier:

2 (A) Shall not deny the individual participation in an approved clinical trial.

3 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose
4 additional conditions on the coverage of routine patient costs for items and services furnished in
5 connection with participation in the approved clinical trial; and

6 (C) Shall not discriminate against the individual on the basis of the individual's
7 participation in the approved clinical trial.

8 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all
9 items and services consistent with the coverage typically covered for a qualified individual who is
10 not enrolled in an approved clinical trial.

11 (B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not
12 include:

13 (i) The investigational item, device or service itself;

14 (ii) Items and services that are provided solely to satisfy data collection and analysis
15 needs and that are not used in the direct clinical management of the patient; or

16 (iii) A service that is clearly inconsistent with widely accepted and established standards
17 of care for a particular diagnosis.

18 (3) If one or more participating providers is participating in a clinical trial, nothing in
19 subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring
20 that a qualified individual participate in the trial through such a participating provider if the
21 provider will accept the individual as a participant in the trial.

22 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection
23 shall apply to a qualified individual participating in an approved clinical trial that is conducted
24 outside this state.

25 (5) This section shall not be construed to require a nonprofit medical service corporation
26 offering group or individual health insurance coverage to provide benefits for routine patient care
27 services provided outside of the coverage's health care provider network unless out-of-network
28 benefits are otherwise provided under the coverage.

29 (6) Nothing in this section shall be construed to limit a health insurance carrier's
30 coverage with respect to clinical trials.

31 (c) The requirements of this section shall be in addition to the requirements of Rhode
32 Island general laws sections 27-18-36 through 27-18-36.3.

33 (d) This section shall not apply to grandfathered health plans. This section shall not apply
34 to insurance coverage providing benefits for: (1) Hospital confinement indemnity; (2) Disability

1 income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit
2 health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident or
3 both; and (9) Other limited benefit policies.

4 (e) This section shall be effective for plan years beginning on or after January 1, 2014.

5 **27-20-61. Medical loss ratio reporting and rebates.** – (a) A nonprofit medical service
6 corporation offering group or individual health insurance coverage of a health benefit plan,
7 including a grandfathered health plan, shall comply with the provisions of Section 2718 of the
8 Public Health Services Act as amended by the federal Affordable Care Act, in accordance with
9 regulations adopted thereunder.

10 (b) Nonprofit medical service corporations required to report medical loss ratio and
11 rebate calculations and any other medical loss ratio and rebate information to the U.S.
12 Department of Health and Human Services shall concurrently file such information with the
13 commissioner.

14 **27-20-62. Emergency services --** (a) As used in this section:

15 (1) “Emergency medical condition” means a medical condition manifesting itself by
16 acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
17 possesses an average knowledge of health and medicine, could reasonably expect the absence of
18 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
19 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
20 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
21 part.

22 (2) “Emergency services” means, with respect to an emergency medical condition:

23 (A) A medical screening examination (as required under section 1867 of the Social
24 Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a
25 hospital, including ancillary services routinely available to the emergency department to evaluate
26 such emergency medical condition, and

27 (B) Such further medical examination and treatment, to the extent they are within the
28 capabilities of the staff and facilities available at the hospital, as are required under section 1867
29 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

30 (3) “Stabilize”, with respect to an emergency medical condition has the meaning given in
31 section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

32 (b) If a nonprofit medical service corporation offering health insurance coverage provides
33 any benefits with respect to services in an emergency department of a hospital, it must cover
34 emergency services consistent with the rules of this section.

1 (c) A nonprofit medical service corporation shall provide coverage for emergency
2 services in the following manner:

3 (1) Without the need for any prior authorization determination, even if the emergency
4 services are provided on an out-of-network basis;

5 (2) Without regard to whether the health care provider furnishing the emergency services
6 is a participating network provider with respect to the services;

7 (3) If the emergency services are provided out of network, without imposing any
8 administrative requirement or limitation on coverage that is more restrictive than the requirements
9 or limitations that apply to emergency services received from in-network providers;

10 (4) If the emergency services are provided out of network, by complying with the cost-
11 sharing requirements of subsection (d) of this section; and

12 (5) Without regard to any other term or condition of the coverage, other than:

13 (A) The exclusion of or coordination of benefits;

14 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
15 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

16 (C) Applicable cost-sharing.

17 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
18 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
19 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
20 the services were provided in-network. However, a participant or beneficiary may be required to
21 pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network
22 provider charges over the amount the plan or health insurance carrier is required to pay under
23 subdivision (1) of this subsection. A group health plan or health insurance carrier complies with
24 the requirements of this subsection if it provides benefits with respect to an emergency service in
25 an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
26 this subdivision (1)(which are adjusted for in-network cost-sharing requirements).

27 (A) The amount negotiated with in-network providers for the emergency service
28 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
29 participant or beneficiary. If there is more than one amount negotiated with in-network providers
30 for the emergency service, the amount described under this subdivision (A) is the median of these
31 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
32 participant or beneficiary. In determining the median described in the preceding sentence, the
33 amount negotiated with each in-network provider is treated as a separate amount (even if the
34 same amount is paid to more than one provider). If there is no per-service amount negotiated with

1 in-network providers (such as under a capitation or other similar payment arrangement), the
2 amount under this subdivision (A) is disregarded.

3 (B) The amount for the emergency service shall be calculated using the same method the
4 plan generally uses to determine payments for out-of-network services (such as the usual,
5 customary, and reasonable amount), excluding any in-network copayment or coinsurance
6 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
7 determined without reduction for out-of-network cost-sharing that generally applies under the
8 plan or health insurance coverage with respect to out-of-network services.

9 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
10 Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network
11 copayment or coinsurance imposed with respect to the participant or beneficiary.

12 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
13 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
14 services provided out of network if the cost-sharing requirement generally applies to out-of-
15 network benefits. A deductible may be imposed with respect to out-of-network emergency
16 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
17 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
18 apply to out-of-network emergency services.

19 (f) The provisions of this section shall apply to grandfathered health plans. This section
20 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
21 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6)
22 Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by
23 accident or both; and (9) Other limited benefit policies.

24 **27-20-63. Internal and external appeal of adverse benefit determinations. -- (a) The**
25 **commissioner shall adopt regulations to implement standards and procedures with respect to**
26 **internal claims and appeals of adverse benefit determinations, and with respect to external appeals**
27 **of adverse benefit determinations.**

28 (b) The regulations adopted by the commissioner shall apply only to those adverse
29 benefit determinations which are not subject to the jurisdiction of the department of health
30 pursuant to R.I. Gen. Laws § 23-17.12 et seq. (Utilization Review Act).

31 (c) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
32 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
33 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
34 bodily injury or death by accident or both; and (9) Other limited benefit policies. This section also

1 [shall not apply to grandfathered health plans.](#)

2 SECTION 9. Sections 27-41-2 and 27-41-61 of the General laws in Chapter 27-41
3 entitled "Health Maintenance Organizations" are hereby amended to read as follows:

4 **27-41-2. Definitions.** – [As used in this chapter:](#)

5 [\(a\) "Adverse benefit determination" means any of the following: a denial, reduction, or](#)
6 [termination of, or a failure to provide or make payment \(in whole or in part\) for, a benefit,](#)
7 [including any such denial, reduction, termination, or failure to provide or make payment that is](#)
8 [based on a determination of a an individual's eligibility to participate in a plan or to receive](#)
9 [coverage under a plan, and including, with respect to group health plans, a denial, reduction, or](#)
10 [termination of, or a failure to provide or make payment \(in whole or in part\) for, a benefit](#)
11 [resulting from the application of any utilization review, as well as a failure to cover an item or](#)
12 [service for which benefits are otherwise provided because it is determined to be experimental or](#)
13 [investigational or not medically necessary or appropriate. The term also includes a rescission of](#)
14 [coverage determination.](#)

15 [\(b\) "Affordable Care Act" means the federal Patient Protection and Affordable Care act](#)
16 [of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and](#)
17 [federal regulations adopted thereunder;](#)

18 [\(c\) "Commissioner" or "health insurance commissioner" means that individual appointed](#)
19 [pursuant to section 42-14.5-1 of the general laws.](#)

20 [\(d\) "Covered health services" means the services that a health maintenance organization](#)
21 [contracts with enrollees and enrolled groups to provide or make available to an enrolled](#)
22 [participant.](#)

23 [\(e\) "Director" means the director of the department of business regulation or his or her](#)
24 [duly appointed agents.](#)

25 [\(f\) "Employee" means any person who has entered into the employment of or works](#)
26 [under a contract of service or apprenticeship with any employer. It shall not include a person who](#)
27 [has been employed for less than thirty \(30\) days by his or her employer, nor shall it include a](#)
28 [person who works less than an average of thirty \(30\) hours per week. For the purposes of this](#)
29 [chapter, the term "employee" means a person employed by an "employer" as defined in](#)
30 [subsection \(d\) of this section. Except as otherwise provided in this chapter the terms "employee"](#)
31 [and "employer" are to be defined according to the rules and regulations of the department of labor](#)
32 [and training.](#)

33 [\(g\) "Employer" means any person, partnership, association, trust, estate, or corporation,](#)
34 [whether foreign or domestic, or the legal representative, trustee in bankruptcy, receiver, or trustee](#)

1 of a receiver, or the legal representative of a deceased person, including the state of Rhode Island
2 and each city and town in the state, which has in its employ one or more individuals during any
3 calendar year. For the purposes of this section, the term "employer" refers only to an employer
4 with persons employed within the state of Rhode Island.

5 (h) "Enrollee" means an individual who has been enrolled in a health maintenance
6 organization.

7 (i) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the
8 federal Affordable Care Act.

9 (j) "Evidence of coverage" means any certificate, agreement, or contract issued to an
10 enrollee setting out the coverage to which the enrollee is entitled.

11 (k) "Grandfathered health plan" means any group health plan or health insurance
12 coverage subject to 42 USC section 18011.

13 (l) "Group health insurance coverage" means, in connection with a group health plan,
14 health insurance coverage offered in connection with such plan.

15 (m) "Group health plan" means an employee welfare benefit plan as defined in 29 USC
16 section 1002(1), to the extent that the plan provides health benefits to employees or their
17 dependents directly or through insurance, reimbursement, or otherwise.

18 (n) "Health benefits" or "covered benefits" means coverage or benefits for the diagnosis,
19 cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting
20 any structure or function of the body including coverage or benefits for transportation primarily
21 for and essential thereto, and including medical services as defined in R.I. Gen. Laws § 27-19-17;

22 (o) "Health care facility" means an institution providing health care services or a health
23 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory
24 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,
25 laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

26 (p) "Health care professional" means a physician or other health care practitioner
27 licensed, accredited or certified to perform specified health care services consistent with state
28 law.

29 (q) "Health care provider" or "provider" means a health care professional or a health care
30 facility.

31 (r) "Health care services" means any services included in the furnishing to any individual
32 of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of that care or
33 hospitalization, and the furnishing to any person of any and all other services for the purpose of
34 preventing, alleviating, curing, or healing human illness, injury, or physical disability.

1 [\(s\) "Health insurance carrier" means a person, firm, corporation or other entity subject to](#)
2 [the jurisdiction of the commissioner under this chapter, and includes a health maintenance](#)
3 [organization. Such term does not include a group health plan.](#)

4 [\(t\) "Health maintenance organization" means a single public or private organization](#)
5 [which:](#)

6 (1) Provides or makes available to enrolled participants health care services, including at
7 least the following basic health care services: usual physician services, hospitalization, laboratory,
8 x-ray, emergency, and preventive services, and out of area coverage, and the services of licensed
9 midwives;

10 (2) Is compensated, except for copayments, for the provision of the basic health care
11 services listed in subdivision (1) of this subsection to enrolled participants on a predetermined
12 periodic rate basis; and

13 (3) Provides physicians' services primarily:

14 (A) Directly through physicians who are either employees or partners of the organization;

15 or

16 (B) Through arrangements with individual physicians or one or more groups of
17 physicians organized on a group practice or individual practice basis;

18 (ii) "Health maintenance organization" does not include prepaid plans offered by entities
19 regulated under chapter 1, 2, 19, or 20 of this title that do not meet the criteria above and do not
20 purport to be health maintenance organizations;

21 (4) Provides the services of licensed midwives primarily:

22 (i) Directly through licensed midwives who are either employees or partners of the
23 organization; or

24 (ii) Through arrangements with individual licensed midwives or one or more groups of
25 licensed midwives organized on a group practice or individual practice basis.

26 (u) "Licensed midwife" means any midwife licensed pursuant to section 23-13-9.

27 (v) "Material modification" means only systemic changes to the information filed under
28 section 27-41-3.

29 (w) "Net worth", for the purposes of this chapter, means the excess of total admitted
30 assets over total liabilities.

31 [\(x\) "Office of the health insurance commissioner" means the agency established under](#)
32 [section 42-14.5-1 of the general laws.](#)

33 [\(y\) "Physician" includes podiatrist as defined in chapter 29 of title 5.](#)

34 [\(z\) "Private organization" means a legal corporation with a policy making and governing](#)

1 body.

2 (aa) "Provider" means any physician, hospital, licensed midwife, or other person who is
3 licensed or authorized in this state to furnish health care services.

4 (bb) "Public organization" means an instrumentality of government.

5 (cc) "Rescission" means a cancellation or discontinuance of coverage that has retroactive
6 effect for reasons unrelated to timely payment of required premiums or contribution to costs of
7 coverage.

8 (dd) "Risk based capital ("RBC") instructions" means the risk based capital report
9 including risk based capital instructions adopted by the National Association of Insurance
10 Commissioners ("NAIC"), as these risk based capital instructions are amended by the NAIC in
11 accordance with the procedures adopted by the NAIC.

12 (ee) "Total adjusted capital" means the sum of:

13 (1) A health maintenance organization's statutory capital and surplus (i.e. net worth) as
14 determined in accordance with the statutory accounting applicable to the annual financial
15 statements required to be filed under section 27-41-9; and

16 (2) Any other items, if any, that the RBC instructions provide.

17 (ff) "Uncovered expenditures" means the costs of health care services that are covered by
18 a health maintenance organization, but that are not guaranteed, insured, or assumed by a person or
19 organization other than the health maintenance organization. Expenditures to a provider that
20 agrees not to bill enrollees under any circumstances are excluded from this definition.

21 **27-41-61. Termination of children's benefits Eligibility for children's benefits --**

22 (a)(1) Every ~~individual health insurance contract, plan, or policy~~ health benefit plan delivered,
23 issued for delivery, or renewed in this state which provides ~~medical~~ health benefits coverage for
24 ~~dependent children that includes coverage for physician services in a physician's office, and~~
25 ~~every policy which provides major medical or similar comprehensive type coverage~~ dependents,
26 except for supplemental policies which only provide coverage for specified diseases and other
27 supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried child under the age~~
28 ~~of nineteen (19) years, an unmarried child who is a student under the age of twenty five (25)~~
29 ~~years and who is financially dependent upon the parent and an unmarried child of any age who is~~
30 ~~financially dependent upon the parent and medically determined to have a physical or mental~~
31 ~~impairment which can be expected to result in death or which has lasted or can be expected to last~~
32 ~~for a continuous period of not less than twelve (12) months~~ for children until attainment of
33 twenty-six (26) years of age, and an unmarried child of any age who is financially dependent
34 upon the parent and medically determined to have a physical or mental impairment which can be

1 expected to result in death or which has lasted or can be expected to last for a continuous period
2 of not less than twelve (12) months. ~~Such contract, plan or policy shall also include a provision~~
3 ~~that policyholders shall receive no less than thirty (30) days notice from the accident and sickness~~
4 ~~insurer that a child covered as a dependent by the policy holder is about to lose his or her~~
5 ~~coverage as a result of reaching the maximum age for a dependent child, and that the child will~~
6 ~~only continue to be covered upon documentation being provided of current full or part time~~
7 ~~enrollment in a post-secondary educational institution or that the child may purchase a conversion~~
8 ~~policy if he or she is not an eligible student. Nothing in this section prohibits an accident and~~
9 ~~sickness insurer from requiring a policy holder to annually provide proof of a child's current full~~
10 ~~or part time enrollment in a post-secondary educational institution in order to maintain the child's~~
11 ~~coverage. Provided, nothing in this section requires coverage inconsistent with the membership~~
12 ~~criteria in effect under the policyholder's health benefits coverage.~~

13 (2) With respect to a child who has not attained twenty-six (26) years of age, a health
14 maintenance organization shall not define "dependent" for purposes of eligibility for dependent
15 coverage of children other than the terms of a relationship between a child and the plan
16 participant, or subscriber.

17 (3) A health maintenance organization shall not deny or restrict coverage for a child who
18 has not attained twenty-six (26) years of age based on the presence or absence of the child's
19 financial dependency upon the participant, primary subscriber or any other person, residency with
20 the participant and in the individual market the primary subscriber, or with any other person,
21 marital status, student status, employment or any combination of those factors. A health carrier
22 shall not deny or restrict coverage of a child based on eligibility for other coverage, except as
23 provided in (b) (1) of this section.

24 (4) Nothing in this section shall be construed to require a health maintenance
25 organization to make coverage available for the child of a child receiving dependent coverage,
26 unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

27 (5) The terms of coverage in a health benefit plan offered by a health maintenance
28 organization providing dependent coverage of children cannot vary based on age except for
29 children who are twenty-six (26) years of age or older.

30 (b)(1) For plan years beginning before January 1, 2014, a group health plan providing
31 group health insurance coverage that is a grandfathered health plan and makes available
32 dependent coverage of children may exclude an adult child who has not attained twenty-six (26)
33 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-
34 sponsored health benefit plan, as defined in section 5000A(f)(2) of the federal Internal Revenue

1 Code, other than the group health plan of a parent.

2 (2) For plan years, beginning on or after January 1, 2014, a group health plan providing
3 group health insurance coverage that is a grandfathered health plan shall comply with the
4 requirements of this section

5 (e) This section does not apply to insurance coverage providing benefits for: (1) hospital
6 confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare
7 supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other limited
8 benefit policies.

9 SECTION 10. Chapter 27-41 of the General laws entitled "Health Maintenance
10 Organizations" is hereby amended by adding thereto the following sections:

11 **27-41-29.1. Uniform explanation of benefits and coverage.** -- (a) A health maintenance
12 organization shall provide a summary of benefits and coverage explanation and definitions to
13 policyholders and others required by, and at the times and in the format required, by the federal
14 regulations adopted under section 2715 of the Public Health Service Act, as amended by the
15 federal Affordable Care Act. The forms required by this section shall be made available to the
16 commissioner on request. Nothing in this section shall be construed to limit the authority of the
17 commissioner under existing state law.

18 (b) The provisions of this section shall apply to grandfathered health plans. This section
19 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
20 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6)
21 Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by
22 accident or both; and (9) Other limited benefit policies.

23 (c) If the commissioner of the office of the health insurance commissioner determines
24 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
25 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
26 an act of Congress, on the date of the commissioner's determination this section shall have its
27 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
28 section. Nothing in this section shall be construed to limit the authority of the commissioner
29 under existing state law.

30 **27-41-29.2. Filing of policy forms.** -- (a) A health maintenance organization shall file all
31 policy forms and rates used by it in the state with the commissioner, including the forms of any
32 rider, endorsement, application blank, and other matter generally used or incorporated by
33 reference in its policies or contracts of insurance. No such form shall be used if disapproved by
34 the commissioner under this section, or if the commissioner's approval has been withdrawn after

1 notice and an opportunity to be heard, or until the expiration of sixty (60) days following the
2 filing of the form. Such a company shall comply with its filed and approved forms. If the
3 commissioner finds from an examination of any form that it is contrary to the public interest or
4 the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and
5 shall notify the corporation in writing.

6 (b) Each rate filing shall include a certification by a qualified actuary that to the best of
7 the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws
8 and that the benefits offered or proposed to be offered are reasonable in relation to the premium
9 to be charged. A health insurance carrier shall comply with its filed and approved rates and
10 forms.

11 **27-41-75. Prohibition on rescission of coverage.** -- (a)(1) Coverage under a health plan
12 subject to the jurisdiction of the commissioner under this chapter with respect to an individual,
13 including a group to which the individual belongs or family coverage in which the individual is
14 included, shall not be rescinded after the individual is covered under the plan, unless:

15 (A) The individual or a person seeking coverage on behalf of the individual, performs an
16 act, practice or omission that constitutes fraud; or

17 (B) The individual makes an intentional misrepresentation of material fact, as prohibited
18 by the terms of the plan or coverage.

19 (2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an
20 individual does not include an insurance producer or employee or authorized representative of the
21 health maintenance organization.

22 (b) At least thirty (30) days advance written notice shall be provided to each plan enrollee
23 or, for individual health insurance coverage, primary subscriber, who would be affected by the
24 proposed rescission of coverage before coverage under the plan may be rescinded in accordance
25 with subsection (a) regardless of, in the case of group health insurance coverage, whether the
26 rescission applies to the entire group or only to an individual within the group.

27 (c) For purposes of this section, “to rescind” means to cancel or to discontinue coverage
28 with retroactive effect for reasons unrelated to timely payment of required premiums or
29 contribution to costs of coverage.

30 (d) This section applies to grandfathered health plans.

31 **27-41-76. Prohibition on annual and lifetime limits.** -- (a) Annual limits.

32 (1) For plan or policy years beginning prior to January 1, 2014, for any individual, a
33 health maintenance organization subject to the jurisdiction of the commissioner under this chapter
34 may establish an annual limit on the dollar amount of benefits that are essential health benefits

1 provided the restricted annual limit is not less than the following:

2 (A) For a plan or policy year beginning after September 22, 2011, but before September
3 23, 2012 – one million two hundred fifty thousand dollars (\$1,250,000); and

4 (B) For a plan or policy year beginning after September 22, 2012, but before January 1,
5 2014 – two million dollars (\$2,000,000).

6 (2) For plan or policy years beginning on or after January 1, 2014, a health maintenance
7 organization shall not establish any annual limit on the dollar amount of essential health benefits
8 for any individual, except:

9 (A) A health flexible spending arrangement, as defined in section 106(c)(2)(i) of the
10 federal Internal Revenue Code, a medical savings account, as defined in section 220 of the federal
11 Internal Revenue Code, and a health savings account, as defined in section 223 of the federal
12 Internal Revenue Code are not subject to the requirements of subdivisions (1) and (2) of this
13 subsection .

14 (B) The provisions of this subsection shall not prevent a health maintenance organization
15 from placing annual dollar limits for any individual on specific covered benefits that are not
16 essential health benefits to the extent that such limits are otherwise permitted under applicable
17 federal law or the laws and regulations of this state.

18 (3) In determining whether an individual has received benefits that meet or exceed the
19 allowable limits, as provided in subdivision (1) of this subsection, a health maintenance
20 organization shall take into account only essential health benefits.

21 (b) Lifetime limits.

22 (1) A health insurance carrier and health benefit plan offering group or individual health
23 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
24 benefits for any individual.

25 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
26 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
27 benefits that are not essential health benefits in accordance with federal laws and regulations.

28 (c)(1) The provisions of this section relating to lifetime limits apply to any health
29 maintenance organization or health insurance carrier providing coverage under an individual or
30 group health plan, including grandfathered health plans.

31 (2) The provisions of this section relating to annual limits apply to any health
32 maintenance organization or health insurance carrier providing coverage under a group health
33 plan, including grandfathered health plans, but the prohibition and limits on annual limits do not
34 apply to grandfathered health plans providing individual health insurance coverage.

1 (d) This section shall not apply to a plan or to policy years prior to January 1, 2014 for
2 which the Secretary of the U.S. Department of Health and Human Services issued a waiver
3 pursuant to 45 C.F.R. § 147.126(d)(3). This section also shall not apply to insurance coverage
4 providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident
5 only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified
6 disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other
7 limited benefit policies.

8 (e) If the commissioner of the office of the health insurance commissioner determines
9 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
10 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
11 an act of Congress, on the date of the commissioner's determination this section shall have its
12 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
13 section. Nothing in this subsection shall be construed to limit the authority of the Commissioner
14 to regulate health insurance under existing state law.

15 **27-41-77. Coverage for individual participating in approved clinical trials. -- (a) As**
16 **used in this section.**

17 (1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial
18 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
19 threatening disease or condition and is described in any of the following:

20 (A) The study or investigation is approved or funded, which may include funding through
21 in-kind contributions, by one or more of the following:

22 (i) The federal National Institutes of Health;

23 (ii) The federal Centers for Disease Control and Prevention;

24 (iii) The federal Agency for Health Care Research and Quality;

25 (iv) The federal Centers for Medicare & Medicaid Services;

26 (v) A cooperative group or center of any of the entities described in items (i) through (iv)
27 or the U.S. Department of Defense or the U.S. Department of Veteran Affairs;

28 (vi) A qualified non-governmental research entity identified in the guidelines issued by
29 the federal National Institutes of Health for center support grants; or

30 (vii) A study or investigation conducted by the U.S. Department of Veteran Affairs, the
31 U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has
32 been reviewed and approved through a system of peer review that the Secretary of U.S.
33 Department of Health and Human Services determines:

34 (I) Is comparable to the system of peer review of studies and investigations used by the

1 federal National Institutes of Health; and

2 (II) Assures unbiased review of the highest scientific standards by qualified individuals
3 who have no interest in the outcome of the review.

4 (B) The study or investigation is conducted under an investigational new drug application
5 reviewed by the U.S. Food and Drug Administration; or

6 (C) The study or investigation is a drug trial that is exempt from having such an
7 investigational new drug application.

8 (2) “Participant” has the meaning stated in section 3(7) of federal ERISA.

9 (3) “Participating provider” means a health care provider that, under a contract with the
10 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
11 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
12 deductibles, directly or indirectly from the health carrier.

13 (4) “Qualified individual” means a participant or beneficiary who meets the following
14 conditions:

15 (A) The individual is eligible to participate in an approved clinical trial according to the
16 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;
17 and

18 (B)(i) The referring health care professional is a participating provider and has concluded
19 that the individual’s participation in such trial would be appropriate based on the individual
20 meeting the conditions described in subdivision (A) of this subdivision (3); or

21 (ii) The participant or beneficiary provides medical and scientific information
22 establishing the individual’s participation in such trial would be appropriate based on the
23 individual meeting the conditions described in subdivision (A) of this subdivision (3).

24 (5) “Life-threatening condition” means any disease or condition from which the
25 likelihood of death is probable unless the course of the disease or condition is interrupted.

26 (b)(1) If a health maintenance organization offering group or individual health insurance
27 coverage provides coverage to a qualified individual, it:

28 (A) Shall not deny the individual participation in an approved clinical trial.

29 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose
30 additional conditions on the coverage of routine patient costs for items and services furnished in
31 connection with participation in the approved clinical trial; and

32 (C) Shall not discriminate against the individual on the basis of the individual’s
33 participation in the approved clinical trial.

34 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all

1 items and services consistent with the coverage typically covered for a qualified individual who is
2 not enrolled in an approved clinical trial.

3 (B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not
4 include:

5 (i) The investigational item, device or service itself;

6 (ii) Items and services that are provided solely to satisfy data collection and analysis
7 needs and that are not used in the direct clinical management of the patient; or

8 (iii) A service that is clearly inconsistent with widely accepted and established standards
9 of care for a particular diagnosis.

10 (3) If one or more participating providers is participating in a clinical trial, nothing in
11 subdivision (1) of this subsection shall be construed as preventing a health maintenance
12 organization from requiring that a qualified individual participate in the trial through such a
13 participating provider if the provider will accept the individual as a participant in the trial.

14 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection
15 shall apply to a qualified individual participating in an approved clinical trial that is conducted
16 outside this state.

17 (5) This section shall not be construed to require a health maintenance organization
18 offering group or individual health insurance coverage to provide benefits for routine patient care
19 services provided outside of the coverage's health care provider network unless out-of-network
20 benefits are other provided under the coverage.

21 (6) Nothing in this section shall be construed to limit a health maintenance organization's
22 coverage with respect to clinical trials.

23 (c) The requirements of this section shall be in addition to the requirements of Rhode
24 Island general laws sections 27-41-41 through 27-41-41.3.

25 (d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
26 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
27 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
28 bodily injury or death by accident or both; and (9) Other limited benefit policies.

29 **27-41-78. Medical loss ratio reporting and rebates. -- (a) A health maintenance**
30 **organization offering group or individual health insurance coverage of a health benefit plan,**
31 **including a grandfathered health plan, shall comply with the provisions of Section 2718 of the**
32 **Public Health Services Act as amended by the federal Affordable Care Act, in accordance with**
33 **regulations adopted thereunder.**

34 **(b) Health maintenance organizations required to report medical loss ratio and rebate**

1 calculations and any other medical loss ratio or rebate information to the U.S. Department of
2 Health and Human Services shall concurrently file such information with the commissioner.

3 **27-41-79. Emergency services.** -- (a) As used in this section:

4 (1) “Emergency medical condition” means a medical condition manifesting itself by
5 acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
6 possesses an average knowledge of health and medicine, could reasonably expect the absence of
7 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
8 with respect to a pregnant woman her unborn child in serious jeopardy; (ii) Constituting a serious
9 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
10 part.

11 (2) “Emergency services” means, with respect to an emergency medical condition:

12 (A) A medical screening examination (as required under section 1867 of the Social
13 Security Act, 42 U.S.C. 1395 dd) that is within the capability of the emergency department of a
14 hospital, including ancillary services routinely available to the emergency department to evaluate
15 such emergency medical condition, and

16 (B) Such further medical examination and treatment, to the extent they are within the
17 capabilities of the staff and facilities available at the hospital, as are required under section 1867
18 of the Social Security Act (42 U.S.C. 1395 dd) to stabilize the patient.

19 (3) “Stabilize”, with respect to an emergency medical condition has the meaning given in
20 section 1867(e)(3) of the Social Security Act (42 U.S.C.1395 dd(e)(3)).

21 (b) If a health maintenance organization offering group health insurance coverage
22 provides any benefits with respect to services in an emergency department of a hospital, it must
23 cover emergency services consistent with the rules of this section.

24 (c) A health maintenance organization shall provide coverage for emergency services in
25 the following manner:

26 (1) Without the need for any prior authorization determination, even if the emergency
27 services are provided on an out-of-network basis;

28 (2) Without regard to whether the health care provider furnishing the emergency services
29 is a participating network provider with respect to the services;

30 (3) If the emergency services are provided out of network, without imposing any
31 administrative requirement or limitation on coverage that is more restrictive than the requirements
32 or limitations that apply to emergency services received from in-network providers;

33 (4) If the emergency services are provided out of network, by complying with the cost-
34 sharing requirements of subsection (d) of this section; and

1 (5) Without regard to any other term or condition of the coverage, other than:

2 (A) The exclusion of or coordination of benefits;

3 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
4 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

5 (C) Applicable cost sharing.

6 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
7 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
8 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
9 the services were provided in-network; provided, however, that a participant or beneficiary may
10 be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-
11 network provider charges over the amount the plan or health maintenance organization is required
12 to pay under subdivision (1) of this subsection. A health maintenance organization complies with
13 the requirements of this subsection if it provides benefits with respect to an emergency service in
14 an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
15 this subdivision (1)(which are adjusted for in-network cost-sharing requirements).

16 (A) The amount negotiated with in-network providers for the emergency service
17 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
18 participant or beneficiary. If there is more than one amount negotiated with in-network providers
19 for the emergency service, the amount described under this subdivision (A) is the median of these
20 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
21 participant or beneficiary. In determining the median described in the preceding sentence, the
22 amount negotiated with each in-network provider is treated as a separate amount (even if the
23 same amount is paid to more than one provider). If there is no per-service amount negotiated with
24 in-network providers (such as under a capitation or other similar payment arrangement), the
25 amount under this subdivision (A) is disregarded.

26 (B) The amount for the emergency service calculated using the same method the plan
27 generally uses to determine payments for out-of-network services (such as the usual, customary,
28 and reasonable amount), excluding any in-network copayment or coinsurance imposed with
29 respect to the participant or beneficiary. The amount in this subdivision (B) is determined without
30 reduction for out-of-network cost sharing that generally applies under the plan or health insurance
31 coverage with respect to out-of-network services.

32 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
33 Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network
34 copayment or coinsurance imposed with respect to the participant or beneficiary.

1 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
2 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
3 services provided out of network if the cost-sharing requirement generally applies to out-of-
4 network benefits. A deductible may be imposed with respect to out-of-network emergency
5 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
6 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
7 apply to out-of-network emergency services.

8 (e) The provisions of this section apply for plan years beginning on or after September
9 23, 2010.

10 (f) The provisions of this section shall apply to grandfathered health plans. This section
11 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
12 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6)
13 Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by
14 accident or both; and (9) Other limited benefit policies.

15 **27-41-80. Internal and external appeal of adverse benefit determinations.** -- (a) The
16 commissioner shall adopt regulations to implement standards and procedures with respect to
17 internal claims and appeals of adverse benefit determinations, and with respect to external appeals
18 of adverse benefit determinations.

19 (b) The regulations adopted by the commissioner shall apply only to those adverse
20 benefit determinations within the jurisdiction of the department of health pursuant to R.I. Gen.
21 Laws § 23-17.12 et seq. (Utilization Review Act).

22 (c) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
23 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
24 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
25 bodily injury or death by accident or both; and (9) Other limited benefit policies. This section also
26 shall not apply to grandfathered health plans.

27 **27-41-81. Prohibition on preexisting condition exclusions.** -- (a) A health insurance
28 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a
29 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

30 (1) Shall not limit or exclude coverage for an individual under the age of nineteen (19) by
31 imposing a preexisting condition exclusion on that individual.

32 (2) For plan or policy years beginning on or after January 1, 2014, shall not limit or
33 exclude coverage for any individual by imposing a preexisting condition exclusion on that
34 individual.

1 (b) As used in this section:

2 (1) "Preexisting condition exclusion" means a limitation or exclusion of benefits,
3 including a denial of coverage, based on the fact that the condition (whether physical or mental)
4 was present before the effective date of coverage, or if the coverage is denied, the date of denial,
5 under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was
6 recommended or received before the effective date of coverage.

7 (2) "Preexisting condition exclusion" means any limitation or exclusion of benefits,
8 including a denial of coverage, applicable to an individual as a result of information relating to an
9 individual's health status before the individual's effective date of coverage, or if the coverage is
10 denied, the date of denial, under the health benefit plan, such as a condition (whether physical or
11 mental) identified as a result of a pre-enrollment questionnaire or physical examination given to
12 the individual, or review of medical records relating to the pre-enrollment period.

13 (c) This section shall not apply to grandfathered health plans providing individual health
14 insurance coverage.

15 (d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
16 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
17 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
18 bodily injury or death by accident or both; and (9) Other limited benefit policies.

19 SECTION 11. Sections 27-50-3 and 27-50-7 of the General Laws in Chapter 27-50
20 entitled "Small Employer Health Insurance Availability Act" are hereby amended to read as
21 follows:

22 **27-50-3. Definitions. [Effective December 31, 2010.]** -- (a) "Actuarial certification"
23 means a written statement signed by a member of the American Academy of Actuaries or other
24 individual acceptable to the director that a small employer carrier is in compliance with the
25 provisions of section 27-50-5, based upon the person's examination and including a review of the
26 appropriate records and the actuarial assumptions and methods used by the small employer carrier
27 in establishing premium rates for applicable health benefit plans.

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

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

34 (d) "Affiliation period" means a period of time that must expire before health insurance

1 coverage provided by a carrier becomes effective, and during which the carrier is not required to
2 provide benefits.

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

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

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

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

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

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

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

16 (7) Has a constitution and bylaws; and

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

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

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

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

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

- 1 (i) A group health plan;
- 2 (ii) A health benefit plan;
- 3 (iii) Part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. section 1395c
4 et seq., or 42 U.S.C. section 1395j et seq., (Medicare);
- 5 (iv) Title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq., (Medicaid),
6 other than coverage consisting solely of benefits under 42 U.S.C. section 1396s (the program for
7 distribution of pediatric vaccines);
- 8 (v) 10 U.S.C. section 1071 et seq., (medical and dental care for members and certain
9 former members of the uniformed services, and for their dependents)(Civilian Health and
10 Medical Program of the Uniformed Services)(CHAMPUS). For purposes of 10 U.S.C. section
11 1071 et seq., "uniformed services" means the armed forces and the commissioned corps of the
12 National Oceanic and Atmospheric Administration and of the Public Health Service;
- 13 (vi) A medical care program of the Indian Health Service or of a tribal organization;
- 14 (vii) A state health benefits risk pool;
- 15 (viii) A health plan offered under 5 U.S.C. section 8901 et seq., (Federal Employees
16 Health Benefits Program (FEHBP));
- 17 (ix) A public health plan, which for purposes of this chapter, means a plan established or
18 maintained by a state, county, or other political subdivision of a state that provides health
19 insurance coverage to individuals enrolled in the plan; or
- 20 (x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. section
21 2504(e)).
- 22 (2) A period of creditable coverage shall not be counted, with respect to enrollment of an
23 individual under a group health plan, if, after the period and before the enrollment date, the
24 individual experiences a significant break in coverage.
- 25 (j) "Dependent" means a spouse, ~~an unmarried~~ child under the age ~~of nineteen (19)~~
26 twenty-six (26) years, ~~an unmarried child who is a student under the age of twenty five (25)~~
27 ~~years~~, and an unmarried child of any age who is financially dependent upon, the parent and is
28 medically determined to have a physical or mental impairment which can be expected to result in
29 death or which has lasted or can be expected to last for a continuous period of not less than
30 twelve (12) months.
- 31 (k) "Director" means the director of the department of business regulation.
- 32 (l) [Deleted by P.L. 2006, ch. 258, section 2, and P.L. 2006, ch. 296, section 2.]
- 33 (m) "Eligible employee" means an employee who works on a full-time basis with a
34 normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the

1 term shall also include an employee who works on a full-time basis with a normal work week of
2 anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this
3 eligibility criterion is applied uniformly among all of the employer's employees and without
4 regard to any health status-related factor. The term includes a self-employed individual, a sole
5 proprietor, a partner of a partnership, and may include an independent contractor, if the self-
6 employed individual, sole proprietor, partner, or independent contractor is included as an
7 employee under a health benefit plan of a small employer, but does not include an employee who
8 works on a temporary or substitute basis or who works less than seventeen and one-half (17.5)
9 hours per week. Any retiree under contract with any independently incorporated fire district is
10 also included in the definition of eligible employee, as well as any former employee of an
11 employer who retired before normal retirement age, as defined by 42 U.S.C. 18002(a)(2)(c) while
12 the employer participates in the early retiree reinsurance program defined by that chapter. Persons
13 covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation
14 Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation
15 requirements pursuant to section 27-50-7(d)(9).

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

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

21 (p) "Family composition" means:

22 (1) Enrollee;

23 (2) Enrollee, spouse and children;

24 (3) Enrollee and spouse; or

25 (4) Enrollee and children.

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

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

34 (s) (1) "Group health plan" means an employee welfare benefit plan as defined in section

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

5 (2) For purposes of this chapter:

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

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

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

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

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

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

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

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

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

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

- 1 (iv) Workers' compensation or similar insurance;
2 (v) Automobile medical payment insurance;
3 (vi) Credit-only insurance;
4 (vii) Coverage for on-site medical clinics; and
5 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant
6 to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other
7 insurance benefits.

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

- 11 (i) Limited scope dental or vision benefits;
12 (ii) Benefits for long-term care, nursing home care, home health care, community-based
13 care, or any combination of those; or
14 (iii) Other similar, limited benefits specified in federal regulations issued pursuant to
15 Pub. L. No. 104-191.

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

- 22 (i) Coverage only for a specified disease or illness; or
23 (ii) Hospital indemnity or other fixed indemnity insurance.

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

- 26 (i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the
27 Social Security Act, 42 U.S.C. section 1395ss(g)(1);
28 (ii) Coverage supplemental to the coverage provided under 10 U.S.C. section 1071 et
29 seq.; or
30 (iii) Similar supplemental coverage provided to coverage under a group health plan.

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

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

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

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

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

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

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

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

16 (1) Health status;

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

18 (3) Claims experience;

19 (4) Receipt of health care;

20 (5) Medical history;

21 (6) Genetic information;

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

24 (8) Disability.

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

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

30 (i) Who meets each of the following provisions:

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

33 (B) The individual lost creditable coverage as a result of cessation of employer
34 contribution, termination of employment or eligibility, reduction in the number of hours of

1 employment, involuntary termination of creditable coverage, or death of a spouse, divorce or
2 legal separation, or the individual and/or dependents are determined to be eligible for RIteCare
3 under chapter 5.1 of title 40 or chapter 12.3 of title 42 or for RIteShare under chapter 8.4 of title
4 40; and

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

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

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

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

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

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

18 (vii) Who meets the requirements for special enrollment pursuant to section 27-50-7 or
19 27-50-8.

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

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

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

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

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

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

33 (aa) "Person" means an individual, a corporation, a partnership, an association, a joint
34 venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any

1 combination of the foregoing.

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

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

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

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

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

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

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

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

25 (hh) "Risk adjustment mechanism" means the mechanism established pursuant to section
26 27-50-16.

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

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

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

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

22 (mm) "Wellness health benefit plan" means a plan developed pursuant to section 27-50-
23 10.

24 (nn) "Health insurance commissioner" or "commissioner" means that individual
25 appointed pursuant to section 42-14.5-1 of the general laws and afforded those powers and duties
26 as set forth in sections 42-14.5-2 and 42-14.5-3 of title 42.

27 (oo) "Low-wage firm" means those with average wages that fall within the bottom
28 quartile of all Rhode Island employers.

29 (pp) "Wellness health benefit plan" means the health benefit plan offered by each small
30 employer carrier pursuant to section 27-50-7.

31 (qq) "Commissioner" means the health insurance commissioner.

32 **27-50-7. Availability of coverage.** -- (a) Until October 1, 2004, for purposes of this
33 section, "small employer" includes any person, firm, corporation, partnership, association, or
34 political subdivision that is actively engaged in business that on at least fifty percent (50%) of its

1 working days during the preceding calendar quarter, employed a combination of no more than
2 fifty (50) and no less than two (2) eligible employees and part-time employees, the majority of
3 whom were employed within this state, and is not formed primarily for purposes of buying health
4 insurance and in which a bona fide employer-employee relationship exists. After October 1, 2004,
5 for the purposes of this section, "small employer" has the meaning used in section 27-50-3(kk).

6 (b) (1) Every small employer carrier shall, as a condition of transacting business in this
7 state with small employers, actively offer to small employers all health benefit plans it actively
8 markets to small employers in this state including a wellness health benefit plan. A small
9 employer carrier shall be considered to be actively marketing a health benefit plan if it offers that
10 plan to any small employer not currently receiving a health benefit plan from the small employer
11 carrier.

12 (2) Subject to subdivision (1) of this subsection, a small employer carrier shall issue any
13 health benefit plan to any eligible small employer that applies for that plan and agrees to make the
14 required premium payments and to satisfy the other reasonable provisions of the health benefit
15 plan not inconsistent with this chapter. However, no carrier is required to issue a health benefit
16 plan to any self-employed individual who is covered by, or is eligible for coverage under, a health
17 benefit plan offered by an employer.

18 (c) (1) A small employer carrier shall file with the director, in a format and manner
19 prescribed by the director, the health benefit plans to be used by the carrier. A health benefit plan
20 filed pursuant to this subdivision may be used by a small employer carrier beginning thirty (30)
21 days after it is filed unless the director disapproves its use.

22 (2) The director may at any time may, after providing notice and an opportunity for a
23 hearing to the small employer carrier, disapprove the continued use by a small employer carrier of
24 a health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

25 (d) Health benefit plans covering small employers shall comply with the following
26 provisions:

27 (1) A health benefit plan shall not deny, exclude, or limit benefits for a covered
28 individual for losses incurred more than six (6) months following the enrollment date of the
29 individual's coverage due to a preexisting condition, or the first date of the waiting period for
30 enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a
31 preexisting condition more restrictively than as defined in section 27-50-3.

32 (2) (i) Except as provided in subdivision (3) of this subsection, a small employer carrier
33 shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of
34 creditable coverage without regard to the specific benefits covered during the period of creditable

1 coverage, provided that the last period of creditable coverage ended on a date not more than
2 ninety (90) days prior to the enrollment date of new coverage.

3 (ii) The aggregate period of creditable coverage does not include any waiting period or
4 affiliation period for the effective date of the new coverage applied by the employer or the carrier,
5 or for the normal application and enrollment process following employment or other triggering
6 event for eligibility.

7 (iii) A carrier that does not use preexisting condition limitations in any of its health
8 benefit plans may impose an affiliation period that:

9 (A) Does not exceed sixty (60) days for new entrants and not to exceed ninety (90) days
10 for late enrollees;

11 (B) During which the carrier charges no premiums and the coverage issued is not
12 effective; and

13 (C) Is applied uniformly, without regard to any health status-related factor.

14 (iv) This section does not preclude application of any waiting period applicable to all
15 new enrollees under the health benefit plan, provided that any carrier-imposed waiting period is
16 no longer than sixty (60) days.

17 (3) (i) Instead of as provided in paragraph (2)(i) of this subsection, a small employer
18 carrier may elect to reduce the period of any preexisting condition exclusion based on coverage of
19 benefits within each of several classes or categories of benefits specified in federal regulations.

20 (ii) A small employer electing to reduce the period of any preexisting condition
21 exclusion using the alternative method described in paragraph (i) of this subdivision shall:

22 (A) Make the election on a uniform basis for all enrollees; and

23 (B) Count a period of creditable coverage with respect to any class or category of
24 benefits if any level of benefits is covered within the class or category.

25 (iii) A small employer carrier electing to reduce the period of any preexisting condition
26 exclusion using the alternative method described under paragraph (i) of this subdivision shall:

27 (A) Prominently state that the election has been made in any disclosure statements
28 concerning coverage under the health benefit plan to each enrollee at the time of enrollment under
29 the plan and to each small employer at the time of the offer or sale of the coverage; and

30 (B) Include in the disclosure statements the effect of the election.

31 (4) (i) A health benefit plan shall accept late enrollees, but may exclude coverage for late
32 enrollees for preexisting conditions for a period not to exceed twelve (12) months.

33 (ii) A small employer carrier shall reduce the period of any preexisting condition
34 exclusion pursuant to subdivision (2) or (3) of this subsection.

1 (5) A small employer carrier shall not impose a preexisting condition exclusion:

2 (i) Relating to pregnancy as a preexisting condition; or

3 (ii) With regard to a child who is covered under any creditable coverage within thirty
4 (30) days of birth, adoption, or placement for adoption, provided that the child does not
5 experience a significant break in coverage, and provided that the child was adopted or placed for
6 adoption before attaining eighteen (18) years of age.

7 (6) A small employer carrier shall not impose a preexisting condition exclusion in the
8 case of a condition for which medical advice, diagnosis, care or treatment was recommended or
9 received for the first time while the covered person held creditable coverage, and the medical
10 advice, diagnosis, care or treatment was a covered benefit under the plan, provided that the
11 creditable coverage was continuous to a date not more than ninety (90) days prior to the
12 enrollment date of the new coverage.

13 (7) (i) A small employer carrier shall permit an employee or a dependent of the
14 employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the group
15 health plan of the small employer during a special enrollment period if:

16 (A) The employee or dependent was covered under a group health plan or had coverage
17 under a health benefit plan at the time coverage was previously offered to the employee or
18 dependent;

19 (B) The employee stated in writing at the time coverage was previously offered that
20 coverage under a group health plan or other health benefit plan was the reason for declining
21 enrollment, but only if the plan sponsor or carrier, if applicable, required that statement at the
22 time coverage was previously offered and provided notice to the employee of the requirement and
23 the consequences of the requirement at that time;

24 (C) The employee's or dependent's coverage described under subparagraph (A) of this
25 paragraph:

26 (I) Was under a COBRA continuation provision and the coverage under this provision
27 has been exhausted; or

28 (II) Was not under a COBRA continuation provision and that other coverage has been
29 terminated as a result of loss of eligibility for coverage, including as a result of a legal separation,
30 divorce, death, termination of employment, or reduction in the number of hours of employment or
31 employer contributions towards that other coverage have been terminated; and

32 (D) Under terms of the group health plan, the employee requests enrollment not later
33 than thirty (30) days after the date of exhaustion of coverage described in item (C)(I) of this
34 paragraph or termination of coverage or employer contribution described in item (C)(II) of this

1 paragraph.

2 (ii) If an employee requests enrollment pursuant to subparagraph (i)(D) of this
3 subdivision, the enrollment is effective not later than the first day of the first calendar month
4 beginning after the date the completed request for enrollment is received.

5 (8) (i) A small employer carrier that makes coverage available under a group health plan
6 with respect to a dependent of an individual shall provide for a dependent special enrollment
7 period described in paragraph (ii) of this subdivision during which the person or, if not enrolled,
8 the individual may be enrolled under the group health plan as a dependent of the individual and,
9 in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a
10 dependent of the individual if the spouse is eligible for coverage if:

11 (A) The individual is a participant under the health benefit plan or has met any waiting
12 period applicable to becoming a participant under the plan and is eligible to be enrolled under the
13 plan, but for a failure to enroll during a previous enrollment period; and

14 (B) A person becomes a dependent of the individual through marriage, birth, or adoption
15 or placement for adoption.

16 (ii) The special enrollment period for individuals that meet the provisions of paragraph
17 (i) of this subdivision is a period of not less than thirty (30) days and begins on the later of:

18 (A) The date dependent coverage is made available; or

19 (B) The date of the marriage, birth, or adoption or placement for adoption described in
20 subparagraph (i)(B) of this subdivision.

21 (iii) If an individual seeks to enroll a dependent during the first thirty (30) days of the
22 dependent special enrollment period described under paragraph (ii) of this subdivision, the
23 coverage of the dependent is effective:

24 (A) In the case of marriage, not later than the first day of the first month beginning after
25 the date the completed request for enrollment is received;

26 (B) In the case of a dependent's birth, as of the date of birth; and

27 (C) In the case of a dependent's adoption or placement for adoption, the date of the
28 adoption or placement for adoption.

29 (9) (i) Except as provided in this subdivision, requirements used by a small employer
30 carrier in determining whether to provide coverage to a small employer, including requirements
31 for minimum participation of eligible employees and minimum employer contributions, shall be
32 applied uniformly among all small employers applying for coverage or receiving coverage from
33 the small employer carrier.

34 (ii) For health benefit plans issued or renewed on or after October 1, 2000, a small

1 employer carrier shall not require a minimum participation level greater than seventy-five percent
2 (75%) of eligible employees.

3 (iii) In applying minimum participation requirements with respect to a small employer, a
4 small employer carrier shall not consider employees or dependents who have creditable coverage
5 in determining whether the applicable percentage of participation is met.

6 (iv) A small employer carrier shall not increase any requirement for minimum employee
7 participation or modify any requirement for minimum employer contribution applicable to a small
8 employer at any time after the small employer has been accepted for coverage.

9 (10) (i) If a small employer carrier offers coverage to a small employer, the small
10 employer carrier shall offer coverage to all of the eligible employees of a small employer and
11 their dependents who apply for enrollment during the period in which the employee first becomes
12 eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to
13 only certain individuals or dependents in a small employer group or to only part of the group.

14 (ii) A small employer carrier shall not place any restriction in regard to any health status-
15 related factor on an eligible employee or dependent with respect to enrollment or plan
16 participation.

17 (iii) Except as permitted under subdivisions (1) and (4) of this subsection, a small
18 employer carrier shall not modify a health benefit plan with respect to a small employer or any
19 eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude
20 coverage or benefits for specific diseases, medical conditions, or services covered by the plan.

21 (e) (1) Subject to subdivision (3) of this subsection, a small employer carrier is not
22 required to offer coverage or accept applications pursuant to subsection (b) of this section in the
23 case of the following:

24 (i) To a small employer, where the small employer does not have eligible individuals
25 who live, work, or reside in the established geographic service area for the network plan;

26 (ii) To an employee, when the employee does not live, work, or reside within the
27 carrier's established geographic service area; or

28 (iii) Within an area where the small employer carrier reasonably anticipates, and
29 demonstrates to the satisfaction of the director, that it will not have the capacity within its
30 established geographic service area to deliver services adequately to enrollees of any additional
31 groups because of its obligations to existing group policyholders and enrollees.

32 (2) A small employer carrier that cannot offer coverage pursuant to paragraph (1)(iii) of
33 this subsection may not offer coverage in the applicable area to new cases of employer groups
34 until the later of one hundred and eighty (180) days following each refusal or the date on which

1 the carrier notifies the director that it has regained capacity to deliver services to new employer
2 groups.

3 (3) A small employer carrier shall apply the provisions of this subsection uniformly to all
4 small employers without regard to the claims experience of a small employer and its employees
5 and their dependents or any health status-related factor relating to the employees and their
6 dependents.

7 (f) (1) A small employer carrier is not required to provide coverage to small employers
8 pursuant to subsection (b) of this section if:

9 (i) For any period of time the director determines the small employer carrier does not
10 have the financial reserves necessary to underwrite additional coverage; and

11 (ii) The small employer carrier is applying this subsection uniformly to all small
12 employers in the small group market in this state consistent with applicable state law and without
13 regard to the claims experience of a small employer and its employees and their dependents or
14 any health status-related factor relating to the employees and their dependents.

15 (2) A small employer carrier that denies coverage in accordance with subdivision (1) of
16 this subsection may not offer coverage in the small group market for the later of:

17 (i) A period of one hundred and eighty (180) days after the date the coverage is denied;
18 or

19 (ii) Until the small employer has demonstrated to the director that it has sufficient
20 financial reserves to underwrite additional coverage.

21 (g) (1) A small employer carrier is not required to provide coverage to small employers
22 pursuant to subsection (b) of this section if the small employer carrier elects not to offer new
23 coverage to small employers in this state.

24 (2) A small employer carrier that elects not to offer new coverage to small employers
25 under this subsection may be allowed, as determined by the director, to maintain its existing
26 policies in this state.

27 (3) A small employer carrier that elects not to offer new coverage to small employers
28 under subdivision (g)(1) shall provide at least one hundred and twenty (120) days notice of its
29 election to the director and is prohibited from writing new business in the small employer market
30 in this state for a period of five (5) years beginning on the date the carrier ceased offering new
31 coverage in this state.

32 (h) No small group carrier may impose a pre-existing condition exclusion pursuant to the
33 provisions of subdivisions 27-50-7(d)(1), 27-50-7(d)(2), 27-50-7(d)(3), 27-50-7(d)(4), 27-50-
34 7(d)(5) and 27-50-7(d)(6) with regard to an individual that is less than nineteen (19) years of age.

1 [With respect to health benefit plans issued on and after January 1, 2014 a small employer carrier](#)
2 [shall offer and issue coverage to small employers and eligible individuals notwithstanding any](#)
3 [pre-existing condition of an employee, member, or individual, or their dependents.](#)

4 SECTION 12. Section 27-18.6-3 of the General laws in Chapter 27-18.6 entitled "Large
5 Group Health Insurance Coverage" is hereby amended to read as follows:

6 **27-18.6-3. Limitation on preexisting condition exclusion.** -- (a) (1) Notwithstanding
7 any of the provisions of this title to the contrary, a group health plan and a health insurance
8 carrier offering group health insurance coverage shall not deny, exclude, or limit benefits with
9 respect to a participant or beneficiary because of a preexisting condition exclusion except if:

10 (i) The exclusion relates to a condition (whether physical or mental), regardless of the
11 cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended
12 or received within the six (6) month period ending on the enrollment date;

13 (ii) The exclusion extends for a period of not more than twelve (12) months (or eighteen
14 (18) months in the case of a late enrollee) after the enrollment date; and

15 (iii) The period of the preexisting condition exclusion is reduced by the aggregate of the
16 periods of creditable coverage, if any, applicable to the participant or the beneficiary as of the
17 enrollment date.

18 (2) For purposes of this section, genetic information shall not be treated as a preexisting
19 condition in the absence of a diagnosis of the condition related to that information.

20 (b) With respect to paragraph (a)(1)(iii) of this section, a period of creditable coverage
21 shall not be counted, with respect to enrollment of an individual under a group health plan, if,
22 after that period and before the enrollment date, there was a sixty-three (63) day period during
23 which the individual was not covered under any creditable coverage.

24 (c) Any period that an individual is in a waiting period for any coverage under a group
25 health plan or for group health insurance or is in an affiliation period shall not be taken into
26 account in determining the continuous period under subsection (b) of this section.

27 (d) Except as otherwise provided in subsection (e) of this section, for purposes of
28 applying paragraph (a)(1)(iii) of this section, a group health plan and a health insurance carrier
29 offering group health insurance coverage shall count a period of creditable coverage without
30 regard to the specific benefits covered during the period.

31 (e) (1) A group health plan or a health insurance carrier offering group health insurance
32 may elect to apply paragraph (a)(1)(iii) of this section based on coverage of benefits within each
33 of several classes or categories of benefits. Those classes or categories of benefits are to be
34 determined by the secretary of the United States Department of Health and Human Services

1 pursuant to regulation. The election shall be made on a uniform basis for all participants and
2 beneficiaries. Under the election, a group health plan or carrier shall count a period of creditable
3 coverage with respect to any class or category of benefits if any level of benefits is covered
4 within the class or category.

5 (2) In the case of an election under this subsection with respect to a group health plan
6 (whether or not health insurance coverage is provided in connection with that plan), the plan
7 shall:

8 (i) Prominently state in any disclosure statements concerning the plan, and state to each
9 enrollee under the plan, that the plan has made the election; and

10 (ii) Include in the statements a description of the effect of this election.

11 (3) In the case of an election under this subsection with respect to health insurance
12 coverage offered by a carrier in the large group market, the carrier shall:

13 (i) Prominently state in any disclosure statements concerning the coverage, and to each
14 employer at the time of the offer or sale of the coverage, that the carrier has made the election;
15 and

16 (ii) Include in the statements a description of the effect of the election.

17 (f) (1) A group health plan and a health insurance carrier offering group health insurance
18 coverage may not impose any preexisting condition exclusion in the case of an individual who, as
19 of the last day of the thirty (30) day period beginning with the date of birth, is covered under
20 creditable coverage.

21 (2) Subdivision (1) of this subsection shall no longer apply to an individual after the end
22 of the first sixty-three (63) day period during all of which the individual was not covered under
23 any creditable coverage. Moreover, any period that an individual is in a waiting period for any
24 coverage under a group health plan (or for group health insurance coverage) or is in an affiliation
25 period shall not be taken into account in determining the continuous period for purposes of
26 determining creditable coverage.

27 (g) (1) A group health plan and a health insurance carrier offering group health insurance
28 coverage may not impose any preexisting condition exclusion in the case of a child who is
29 adopted or placed for adoption before attaining eighteen (18) years of age and who, as of the last
30 day of the thirty (30) day period beginning on the date of the adoption or placement for adoption,
31 is covered under creditable coverage. The previous sentence does not apply to coverage before
32 the date of the adoption or placement for adoption.

33 (2) Subdivision (1) of this subsection shall no longer apply to an individual after the end
34 of the first sixty-three (63) day period during all of which the individual was not covered under

1 any creditable coverage. Any period that an individual is in a waiting period for any coverage
2 under a group health plan (or for group health insurance coverage) or is in an affiliation period
3 shall not be taken into account in determining the continuous period for purposes of determining
4 creditable coverage.

5 (h) A group health plan and a health insurance carrier offering group health insurance
6 coverage may not impose any preexisting condition exclusion relating to pregnancy as a
7 preexisting condition or with regard to an individual who is under nineteen (19) years of age.

8 (i) (1) Periods of creditable coverage with respect to an individual shall be established
9 through presentation of certifications. A group health plan and a health insurance carrier offering
10 group health insurance coverage shall provide certifications:

11 (i) At the time an individual ceases to be covered under the plan or becomes covered
12 under a COBRA continuation provision;

13 (ii) In the case of an individual becoming covered under a continuation provision, at the
14 time the individual ceases to be covered under that provision; and

15 (iii) On the request of an individual made not later than twenty-four (24) months after the
16 date of cessation of the coverage described in paragraph (i) or (ii) of this subdivision, whichever
17 is later.

18 (2) The certification under this subsection may be provided, to the extent practicable, at a
19 time consistent with notices required under any applicable COBRA continuation provision.

20 (3) The certification described in this subsection is a written certification of:

21 (i) The period of creditable coverage of the individual under the plan and the coverage (if
22 any) under the COBRA continuation provision; and

23 (ii) The waiting period (if any) (and affiliation period, if applicable) imposed with respect
24 to the individual for any coverage under the plan.

25 (4) To the extent that medical care under a group health plan consists of group health
26 insurance coverage, the plan is deemed to have satisfied the certification requirement under this
27 subsection if the health insurance carrier offering the coverage provides for the certification in
28 accordance with this subsection.

29 (5) In the case of an election taken pursuant to subsection (e) of this section by a group
30 health plan or a health insurance carrier, if the plan or carrier enrolls an individual for coverage
31 under the plan and the individual provides a certification of creditable coverage, upon request of
32 the plan or carrier, the entity which issued the certification shall promptly disclose to the
33 requisition plan or carrier information on coverage of classes and categories of health benefits
34 available under that entity's plan or coverage, and the entity may charge the requesting plan or

1 carrier for the reasonable cost of disclosing the information.

2 (6) Failure of an entity to provide information under this subsection with respect to
3 previous coverage of an individual so as to adversely affect any subsequent coverage of the
4 individual under another group health plan or health insurance coverage, as determined in
5 accordance with rules and regulations established by the secretary of the United States
6 Department of Health and Human Services, is a violation of this chapter.

7 (j) A group health plan and a health insurance carrier offering group health insurance
8 coverage in connection with a group health plan shall permit an employee who is eligible, but not
9 enrolled, for coverage under the terms of the plan (or a dependent of an employee if the
10 dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under
11 the terms of the plan if each of the following conditions are met:

12 (1) The employee or dependent was covered under a group health plan or had health
13 insurance coverage at the time coverage was previously offered to the employee or dependent;

14 (2) The employee stated in writing at the time that coverage under a group health plan or
15 health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or
16 carrier (if applicable) required a statement at the time and provided the employee with notice of
17 that requirement (and the consequences of the requirement) at the time;

18 (3) The employee's or dependent's coverage described in subsection (j)(1):

19 (i) Was under a COBRA continuation provision and the coverage under that provision
20 was exhausted; or

21 (ii) Was not under a continuation provision and either the coverage was terminated as a
22 result of loss of eligibility for the coverage (including as a result of legal separation, divorce,
23 death, termination of employment, or reduction in the number of hours of employment) or
24 employer contributions towards the coverage were terminated; and

25 (4) Under the terms of the plan, the employee requests enrollment not later than thirty
26 (30) days after the date of exhaustion of coverage described in paragraph (3)(i) of this subsection
27 or termination of coverage or employer contribution described in paragraph (3)(ii) of this
28 subsection.

29 (k) (1) If a group health plan makes coverage available with respect to a dependent of an
30 individual, the individual is a participant under the plan (or has met any waiting period applicable
31 to becoming a participant under the plan and is eligible to be enrolled under the plan but for a
32 failure to enroll during a previous enrollment period), and a person becomes a dependent of the
33 individual through marriage, birth, or adoption or placement through adoption, the group health
34 plan shall provide for a dependent special enrollment period during which the person (or, if not

1 enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in
2 the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a
3 dependent of the individual if the spouse is eligible for coverage.

4 (2) A dependent special enrollment period shall be a period of not less than thirty (30)
5 days and shall begin on the later of:

6 (i) The date dependent coverage is made available; or

7 (ii) The date of the marriage, birth, or adoption or placement for adoption (as the case
8 may be).

9 (3) If an individual seeks to enroll a dependent during the first thirty (30) days of a
10 dependent special enrollment period, the coverage of the dependent shall become effective:

11 (i) In the case of marriage, not later than the first day of the first month beginning after
12 the date the completed request for enrollment is received;

13 (ii) In the case of a dependent's birth, as of the date of the birth; or

14 (iii) In the case of a dependent's adoption or placement for adoption, the date of the
15 adoption or placement for adoption.

16 (1) (1) A health maintenance organization which offers health insurance coverage in
17 connection with a group health plan and which does not impose any preexisting condition
18 exclusion allowed under subsection (a) of this section with respect to any particular coverage
19 option may impose an affiliation period for the coverage option, but only if that period is applied
20 uniformly without regard to any health status-related factors, and the period does not exceed two
21 (2) months (or three (3) months in the case of a late enrollee).

22 (2) For the purposes of this subsection, an affiliation shall begin on the enrollment date.

23 (3) An affiliation period under a plan shall run concurrently with any waiting period
24 under the plan.

25 (4) The director may approve alternative methods from those described under this
26 subsection to address adverse selection.

27 (m) For the purpose of determining creditable coverage pursuant to this chapter, no
28 period before July 1, 1996, shall be taken into account. Individuals who need to establish
29 creditable coverage for periods before July 1, 1996, and who would have the coverage credited
30 but for the prohibition in the preceding sentence may be given credit for creditable coverage for
31 those periods through the presentation of documents or other means in accordance with any rule
32 or regulation that may be established by the secretary of the United States Department of Health
33 and Human Services.

34 (n) In the case of an individual who seeks to establish creditable coverage for any period

1 for which certification is not required because it relates to an event occurring before June 30,
2 1996, the individual may present other credible evidence of coverage in order to establish the
3 period of creditable coverage. The group health plan and a health insurance carrier shall not be
4 subject to any penalty or enforcement action with respect to the plan's or carrier's crediting (or not
5 crediting) the coverage if the plan or carrier has sought to comply in good faith with the
6 applicable requirements of this section.

7 (o) Notwithstanding the provisions of any general or public law to the contrary, for plan
8 or policy years beginning on and after January 1, 2014, a group health plan and a health insurance
9 carrier offering group health insurance coverage shall not deny, exclude, or limit benefits with
10 respect to a participant or beneficiary because of a preexisting condition exclusion.

11 SECTION. 13 Applicability and Construction.

12 (a) This act shall apply only to health insurance policies, subscriber contracts, and any
13 other health benefit contract issued on and after July 1, 2012 notwithstanding any other provision
14 of this act.

15 (b) In its construction and enforcement of the provisions of this act, and in the interests of
16 promoting uniform national rules for health insurance carriers, the office of the health insurance
17 commissioner shall give due deference to the construction, enforcement policies, and guidance of
18 the federal government with respect to federal law substantially similar to the provisions of this
19 act.

20 SECTION 14. Sections 27-18-36, 27-18-36.1, 27-18-36.2 and 27-18-36.3 of the General
21 Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" are hereby repealed
22 on the effective date of RI General Law 27-18-80.

23 ~~**27-18-36. New cancer therapies -- Under investigation.** -- Every individual or group~~
24 ~~hospital or medical expense insurance policy or individual or group hospital or medical service~~
25 ~~plan contract delivered, issued for delivery or renewed in this state, except policies which only~~
26 ~~provide coverage for specified diseases other than cancer, fixed indemnity, disability income,~~
27 ~~accident only, long term care Medicare supplement limited benefit health, sickness or bodily~~
28 ~~injury or death by accident or both, or other limited benefit policies, shall provide coverage for~~
29 ~~new cancer therapies still under investigation as outlined in this chapter.~~

30 ~~**27-18-36.1. "Reliable evidence" defined.** -- "Reliable evidence" means:~~

31 ~~(1) Evidence including published reports and articles in authoritative, peer reviewed~~
32 ~~medical and scientific literature;~~

33 ~~(2) A written informed consent used by the treating facility or by another facility~~
34 ~~studying substantially the same service; or~~

1 ~~(3) A written protocol or protocols used by the treating facility or protocols of another~~
2 ~~facility studying substantially the same service.~~

3 ~~**27-18-36.2. Conditions of coverage.**—As provided in section 27-18-36, coverage shall~~
4 ~~be extended to new cancer therapies still under investigation when the following circumstances~~
5 ~~are present:~~

6 ~~(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has~~
7 ~~been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer~~
8 ~~Institute (NCI), Community clinical oncology programs; the Food and Drug Administration in the~~
9 ~~form of an Investigational New Drug (IND) exemption; the Department of Veterans' Affairs; or a~~
10 ~~qualified nongovernmental research entity as identified in the guidelines for NCI cancer center~~
11 ~~support grants;~~

12 ~~(2) The proposed therapy has been reviewed and approved by a qualified institutional~~
13 ~~review board (IRB);~~

14 ~~(3) The facility and personnel providing the treatment are capable of doing so by virtue~~
15 ~~of their experience, training, and volume of patients treated to maintain expertise;~~

16 ~~(4) The patients receiving the investigational treatment meet all protocol requirements;~~

17 ~~(5) There is no clearly superior, noninvestigational alternative to the protocol treatment;~~

18 ~~(6) The available clinical or preclinical data provide a reasonable expectation that the~~
19 ~~protocol treatment will be at least as efficacious as the noninvestigational alternative; and~~

20 ~~(7) The coverage of new cancer therapy treatment provided pursuant to a Phase II~~
21 ~~clinical trial shall not be required for only that portion of that treatment provided as part of the~~
22 ~~phase II clinical trial and is otherwise funded by a national agency, such as the National Cancer~~
23 ~~Institute, the Veteran's Administration, the Department of Defense, or funded by commercial~~
24 ~~organizations such as the biotechnical and/or pharmaceutical industry or manufacturers of~~
25 ~~medical devices. Any portions of a Phase II trial which are customarily funded by government,~~
26 ~~biotechnical and/or pharmaceutical and/or medical device industry sources in Rhode Island or in~~
27 ~~other states shall continue to be so funded in Rhode Island and coverage pursuant to this section~~
28 ~~shall supplement, not supplant, customary funding.~~

29 ~~**27-18-36.3. Managed care.**—Nothing in this chapter shall preclude the conducting of~~
30 ~~managed care reviews and medical necessity reviews by an insurer, hospital or medical service~~
31 ~~corporation, or health maintenance organization.~~

32 SECTION 15. Sections 27-19-32, 27-19-32.1, 27-19-32.2 and 27-19-32.3 of the General
33 Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" are hereby repealed on
34 the effective date of RI General Law 27-19-64.

1 ~~**27-19-32. New cancer therapies -- Under investigation.**~~ Every individual or group
2 hospital or medical expense insurance policy or individual or group hospital or medical service
3 plan contract delivered, issued for delivery or renewed in this state shall provide coverage for new
4 cancer therapies still under investigation as outlined in this chapter.

5 ~~**27-19-32.1. "Reliable evidence" defined.**~~ "Reliable evidence" means:

6 ~~(1) Evidence including published reports and articles in authoritative, peer reviewed~~
7 ~~medical and scientific literature;~~

8 ~~(2) A written informed consent used by the treating facility or by another facility~~
9 ~~studying substantially the same service; or~~

10 ~~(3) A written protocol or protocols used by the treating facility or protocols of another~~
11 ~~facility studying substantially the same service.~~

12 ~~**27-19-32.2. Conditions of coverage.**~~ As provided in section 27-19-32, coverage shall
13 be extended to new cancer therapies still under investigation when the following circumstances
14 are present:

15 ~~(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has~~
16 ~~been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer~~
17 ~~Institute (NCI), community clinical oncology programs; the Food and Drug Administration in the~~
18 ~~form of an investigation new drug (IND) exemption; the Department of Veterans' Affairs; or a~~
19 ~~qualified nongovernmental research entity as identified in the guidelines for NCI cancer center~~
20 ~~support grants;~~

21 ~~(2) The proposed therapy has been reviewed and approved by a qualified institutional~~
22 ~~review board (IRB);~~

23 ~~(3) The facility and personnel providing the treatment are capable of doing so by virtue~~
24 ~~of their experience, training, and volume of patients treated to maintain expertise;~~

25 ~~(4) The patients receiving the investigational treatment meet all protocol requirements;~~

26 ~~(5) There is no clearly superior, noninvestigational alternative to the protocol treatment;~~

27 ~~(6) The available clinical or preclinical data provide a reasonable expectation that the~~
28 ~~protocol treatment will be at least as efficacious as the noninvestigational alternative; and~~

29 ~~(7) The coverage of new cancer therapy treatment provided pursuant to a phase II~~
30 ~~clinical trial shall not be required for that portion of that treatment that is provided as part of the~~
31 ~~phase II clinical trial and is funded by a national agency, such as the National Cancer Institute,~~
32 ~~the Veteran's Administration, the Department of Defense, or funded by commercial organizations~~
33 ~~such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any~~
34 ~~portions of a phase II trial which are customarily funded by government, biotechnical and/or~~

1 ~~pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall~~
2 ~~continue to be funded in Rhode Island and coverage pursuant to this section shall supplement, not~~
3 ~~supplant, customary funding.~~

4 ~~**27-19-32.3. Managed care.** -- Nothing in this chapter shall preclude the conducting of~~
5 ~~managed care reviews and medical necessity reviews by an insurer, hospital or medical service~~
6 ~~corporation, or health maintenance corporation.~~

7 SECTION 16. Sections 27-20-27, 27-20-27.1, 27-20-27.2 and 27-20-27.3 of the General
8 Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" are hereby repealed on
9 the effective date of RI General Law 27-20-64.

10 ~~**27-20-27. New cancer therapies -- Under investigation.** -- Every individual or group~~
11 ~~hospital or medical expense insurance policy or individual or group hospital or medical service~~
12 ~~plan contract delivered, issued for delivery or renewed in this state shall provide coverage for new~~
13 ~~cancer therapies still under investigation as outlined in this chapter.~~

14 ~~**27-20-27.1. "Reliable evidence" defined.** -- "Reliable evidence" means:~~

15 ~~(1) Evidence including published reports and articles in authoritative, peer reviewed~~
16 ~~medical and scientific literature;~~

17 ~~(2) A written informed consent used by the treating facility or by another facility~~
18 ~~studying substantially the same service; or~~

19 ~~(3) A written protocol or protocols used by the treating facility or protocols of another~~
20 ~~facility studying substantially the same service.~~

21 ~~**27-20-27.2. Conditions of coverage.** -- As provided in section 27-20-27, coverage shall~~
22 ~~be extended to new cancer therapies still under investigation when the following circumstances~~
23 ~~are present:~~

24 ~~(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has~~
25 ~~been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer~~
26 ~~Institute (NCI), community clinical oncology programs; the Food and Drug Administration in the~~
27 ~~form of an investigational new drug (IND) exemption; the Department of Veterans' Affairs; or a~~
28 ~~qualified nongovernmental research entity as identified in the guidelines for NCI cancer center~~
29 ~~support grants;~~

30 ~~(2) The proposed therapy has been reviewed and approved by a qualified institutional~~
31 ~~review board (IRB);~~

32 ~~(3) The facility and personnel providing the treatment are capable of doing so by virtue~~
33 ~~of their experience, training, and volume of patients treated to maintain expertise;~~

34 ~~(4) The patients receiving the investigational treatment meet all protocol requirements;~~

1 ~~(5) There is no clearly superior, noninvestigational alternative to the protocol treatment;~~

2 ~~(6) The available clinical or preclinical data provide a reasonable expectation that the~~
3 ~~protocol treatment will be at least as efficacious as the noninvestigational alternative; and~~

4 ~~(7) The coverage of new cancer therapy treatment provided pursuant to a phase II~~
5 ~~clinical trial is not required for only that portion of that treatment that is provided as part of the~~
6 ~~phase II clinical trial and is funded by a national agency, such as the National Cancer Institute,~~
7 ~~the Veteran's Administration, the Department of Defense, or funded by commercial organizations~~
8 ~~such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any~~
9 ~~portions of a phase II trial which are customarily funded by government, biotechnical and/or~~
10 ~~pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall~~
11 ~~continue to be funded in Rhode Island and coverage pursuant to this section supplements, does~~
12 ~~not supplant customary funding.~~

13 ~~**27-20-27.3. Managed care.** Nothing in this chapter shall preclude the conducting of~~
14 ~~managed care reviews and medical necessity reviews by an insurer, hospital or medical service~~
15 ~~corporation, or health maintenance organization. A nonprofit medical service corporation may, as~~
16 ~~a condition of coverage, require its members to obtain new cancer therapies still under~~
17 ~~investigation as outlined in this chapter from providers and facilities designated by the nonprofit~~
18 ~~medical service corporation to render these new cancer therapies.~~

19 SECTION 17. Sections 27-41-41, 27-41-41.1, 27-41-41.2 and 27-41-41.3 of the General
20 Laws in Chapter 27-41 entitled "Health Maintenance Organizations" are hereby repealed on the
21 effective date of RI General Law 27-41-77.

22 ~~**27-41-41. New cancer therapies -- Under investigation.** Every individual or group~~
23 ~~hospital or medical expense insurance policy or individual or group hospital or medical service~~
24 ~~plan contract delivered, issued for delivery or renewed in this state shall provide coverage for new~~
25 ~~cancer therapies still under investigation as outlined in this chapter.~~

26 ~~**27-41-41.1. "Reliable evidence" defined.** "Reliable evidence" means:~~

27 ~~(1) Evidence including published reports and articles in authoritative, peer reviewed~~
28 ~~medical and scientific literature;~~

29 ~~(2) A written informed consent used by the treating facility or by another facility~~
30 ~~studying substantially the same service; or~~

31 ~~(3) A written protocol or protocols used by the treating facility or protocols of another~~
32 ~~facility studying substantially the same service.~~

33 ~~**27-41-41.2. Conditions of coverage.** As provided in section 27-41-41, coverage shall~~
34 ~~be extended to new cancer therapies still under investigation when the following circumstances~~

1 are present:

2 ~~(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has~~
3 ~~been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer~~
4 ~~Institute (NCI), community clinical oncology programs; the food and drug administration in the~~
5 ~~form of an investigational new drug (IND) exemption; the Department of Veterans' Affairs; or a~~
6 ~~qualified nongovernmental research entity as identified in the guidelines for NCI cancer center~~
7 ~~support grants;~~

8 ~~(2) The proposed therapy has been reviewed and approved by a qualified institutional~~
9 ~~review board (IRB);~~

10 ~~(3) The facility and personnel providing the treatment are capable of doing so by virtue~~
11 ~~of their experience, training, and volume of patients treated to maintain expertise;~~

12 ~~(4) The patients receiving the investigational treatment meet all protocol requirements;~~

13 ~~(5) There are no clearly superior, noninvestigational alternatives to the protocol~~
14 ~~treatment;~~

15 ~~(6) The available clinical or preclinical data provide a reasonable expectation that the~~
16 ~~protocol treatment will be at least as efficacious as the noninvestigational alternative; and~~

17 ~~(7) The coverage of new cancer therapy treatment provided pursuant to a phase II~~
18 ~~clinical trial is not required for only the portion of that treatment that is provided as part of the~~
19 ~~phase II clinical trial and is funded by a national agency, such as the National Cancer Institute,~~
20 ~~the Veteran's Administration, the Department of Defense, or funded by commercial organizations~~
21 ~~such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any~~
22 ~~portions of a phase II trial which are customarily funded by government, biotechnical and/or~~
23 ~~pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall~~
24 ~~continue to be funded in Rhode Island and coverage pursuant to this section supplements, but~~
25 ~~does not supplant, that customary funding.~~

26 ~~**27-41-41.3. Managed care.** Nothing in this chapter shall preclude the conducting of~~
27 ~~managed care reviews and medical necessity reviews by an insurer, hospital or medical service~~
28 ~~corporation, or health maintenance organization. A health maintenance organization may as a~~
29 ~~condition of coverage require its members to obtain these new cancer therapies still under~~
30 ~~investigation from providers and facilities designated by the health maintenance organization to~~
31 ~~render these new cancer therapies.~~

32 SECTION18. This act shall take effect upon passage.

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LC02084/SUB A/2
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE -- HEALTH INSURANCE - CONSUMER PROTECTION

1 This act would establish health insurance standards consistent with the health insurance
2 standards established in the Patient Protection and Affordable Care Act of 2010, as amended by
3 the Health Care and Education Reconciliation Act of 2010. These rules and standards would
4 include, but are not limited to, prohibitions on rescission of coverage, discrimination in coverage,
5 and prohibitions on annual and lifetime limits of coverage unless such limits meet set minimum
6 amounts, as well as adding definitions to the chapters covering health insurance. Specific
7 provisions of this act shall not be enforced by the commissioner of the RI Office of the Health
8 Insurance Commissioner in the event that corresponding sections of the Patient Protection and
9 Affordable Care Act are repealed or found invalid.

10 This act would take effect upon passage.

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LC02084/SUB A/2
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