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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2012

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:

SECTION 1. Purpose and intent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

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

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

(i) Limited scope dental or vision benefits.

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

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

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

federal Social Security Act.

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

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

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

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

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

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

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

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

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

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

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

(b) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

(d) This section applies to grandfathered health plans.

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

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

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

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

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

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

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

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

(b) Lifetime limits.

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

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

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

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

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

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

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

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

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

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

(i) The federal National Institutes of Health;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) The participant or beneficiary provides medical and scientific information establishing the individual’s participation in such trial would be appropriate based on the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) "Emergency services" means, with respect to an emergency medical condition:

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

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

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

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

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

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

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

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

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

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

(A) The exclusion of or coordination of benefits;

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

(C) Applicable cost-sharing.

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

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

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

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

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

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

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

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

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

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

pursuant to R.I. Gen. Laws § 23-17.12 et seq. (Utilization Review Act).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Notice Requirements:

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

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

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

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

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

27-18-59. ~~Termination of children's benefits~~ Eligibility for children's benefits. -- (a)(1) Every ~~individual health insurance contract, plan, or policy~~ health benefit plan delivered, issued for delivery, or renewed in this state and every group health insurance contract, plan, or policy delivered, issued for delivery or renewed in this state which provides ~~medical~~ health benefits coverage for ~~dependent children that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage~~ dependents, except for supplemental policies which only provide coverage for specified diseases and other supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried~~

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) “Grandfathered health plan” means any group health plan or health insurance coverage subject to 42 USC section 18011;

(8) “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan;

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

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

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

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

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

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

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

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

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

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

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

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

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

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

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

(i) Limited scope dental or vision benefits.

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

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

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

27-19-50. ~~Termination of children’s benefits~~ Eligibility for children's benefits. -- (a)(1) Every ~~individual health insurance contract, plan, or policy~~ health benefit plan delivered, issued for delivery, or renewed in this state which provides ~~medical~~ health benefits coverage for ~~dependent children that includes coverage for physician services in a physician’s office, and every policy which provides major medical or similar comprehensive type coverage~~ dependents, except for supplemental policies which only provide coverage for specified diseases and other supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried child under the age of nineteen (19) years, an unmarried child who is a student under the age of twenty five (25) years and who is financially dependent upon the parent and an unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months~~ for children until attainment of twenty-six (26) years of age, and an unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months. ~~Such contract, plan or policy shall also include a provision that policyholders shall receive no less than thirty (30) days notice from the accident and sickness insurer that a child covered as a dependent by the policy holder is about to lose his or her coverage as a result of reaching the maximum age for a dependent child, and that the child will only continue to be covered upon documentation being provided of current full or part-time~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) This section applies to grandfathered health plans.

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

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

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

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

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

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

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

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

(b) Lifetime limits.

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

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

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

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

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

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

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

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

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

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

(i) The federal National Institutes of Health;

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) "Qualified individual" means a participant or beneficiary who meets the following conditions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The requirements of this section shall be in addition to the requirements of Rhode Island general laws sections 27-18-32 through 27-19-32.2.

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

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

27-19-65. Medical loss ratio reporting and rebates. – (a) A nonprofit hospital service corporation offering group or individual health insurance coverage of a health benefit plan, including a grandfathered health plan, shall comply with the provisions of Section 2718 of the Public Health Services Act as amended by the federal Affordable Care Act, in accordance with regulations adopted thereunder.

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

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

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

(2) "Emergency services" means, with respect to an emergency medical condition:

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

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

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

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

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

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

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

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

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

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

(A) The exclusion of or coordination of benefits;

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

(C) Applicable cost sharing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) As used in this section:

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

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

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

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

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

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

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

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

~~(1)~~(3) "Certified registered nurse practitioners" is an expanded role utilizing independent knowledge of physical assessment and management of health care and illnesses. The practice includes collaboration with other licensed health care professionals including, but not limited to, physicians, pharmacists, podiatrists, dentists, and nurses;

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

~~(2)~~(5) "Counselor in mental health" means a person who has been licensed pursuant to section 5-63.2-9.

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

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

~~(~~8) “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

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

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

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

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

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

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

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

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

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

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

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

(iv) Workers’ compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

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

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

(i) Limited scope dental or vision benefits.

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

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

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

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

~~(3)~~(17)"Licensed midwife" means any midwife licensed under section 23-13-9;

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

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

~~(6)~~(20) "Nonprofit medical service plan" means a plan by which specified medical service is provided to subscribers to the plan by a nonprofit medical service corporation;

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

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

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

~~(8)~~(24) "Subscribers" means those persons or groups of persons who contract with a

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

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

27-20-45. ~~Termination of children's benefits~~ Eligibility for children's benefits. -- (a)(1) Every ~~individual health insurance contract, plan, or policy~~ health benefit plan delivered, issued for delivery, or renewed in this state ~~and every group health insurance contract, plan, or policy delivered, issued for delivery or renewed in this state~~ which provides ~~medical~~ health benefits coverage for ~~dependent children that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage~~ dependents, except for supplemental policies which only provide coverage for specified diseases and other supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried child under the age of nineteen (19) years, an unmarried child who is a student under the age of twenty-five (25) years and who is financially dependent upon the parent and an unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months~~ for children until attainment of twenty-six (26) years of age, and an unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months. ~~Such contract, plan or policy shall also include a provision that policyholders shall receive no less than thirty (30) days notice from the accident and sickness insurer that a child covered as a dependent by the policy holder is about to lose his or her coverage as a result of reaching the maximum age for a dependent child, and that the child will only continue to be covered upon documentation being provided of current full or part-time enrollment in a post-secondary educational institution or that the child may purchase a conversion policy if he or she is not an eligible student.~~

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

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

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

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

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

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

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

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

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

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

commissioner under existing state law.

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

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

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

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

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

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

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

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

(b) As used in this section:

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

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

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

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

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

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

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

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

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

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

(c) This section applies to grandfathered health plans.

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

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

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

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

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

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

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

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

(b) Lifetime limits.

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

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

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

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

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

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

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

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

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

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

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

(i) The federal National Institutes of Health;

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

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

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

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

or the U.S. Department of Defense or the U.S. Department of Veteran Affairs;

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

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

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

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

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

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

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

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

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

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

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

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

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

(b)(1) If a health insurance carrier offering group or individual health insurance coverage

provides coverage to a qualified individual, the health carrier:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) "Emergency services" means, with respect to an emergency medical condition:

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

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

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

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

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

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

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

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

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

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

(A) The exclusion of or coordination of benefits;

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

(C) Applicable cost-sharing.

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

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

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

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

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

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

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

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

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

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

shall not apply to grandfathered health plans.

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

27-41-2. Definitions. – As used in this chapter:

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

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

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

(d) "Covered health services" means the services that a health maintenance organization contracts with enrollees and enrolled groups to provide or make available to an enrolled participant.

(e) "Director" means the director of the department of business regulation or his or her duly appointed agents.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(s) “Health insurance carrier” means a person, firm, corporation or other entity subject to the jurisdiction of the commissioner under this chapter, and includes a health maintenance organization. Such term does not include a group health plan.

(t) "Health maintenance organization" means a single public or private organization which:

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

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

(3) Provides physicians' services primarily:

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

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

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

(4) Provides the services of licensed midwives primarily:

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

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

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

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

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

(x) "Office of the health insurance commissioner" means the agency established under section 42-14.5-1 of the general laws.

(y) "Physician" includes podiatrist as defined in chapter 29 of title 5.

(z) "Private organization" means a legal corporation with a policy making and governing

body.

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

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

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

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

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

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

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

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

27-41-61. ~~Termination of children's benefits~~ Eligibility for children’s benefits --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) This section applies to grandfathered health plans.

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

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

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

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

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

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

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

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

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

(b) Lifetime limits.

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

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

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

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

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

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

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

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

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

(i) The federal National Institutes of Health;

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

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

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

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

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

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

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

federal National Institutes of Health; and

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

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

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

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

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

(4) "Qualified individual" means a participant or beneficiary who meets the following conditions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) "Emergency services" means, with respect to an emergency medical condition:

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

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

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

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

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

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

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

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

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

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

(A) The exclusion of or coordination of benefits;

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

(C) Applicable cost sharing.

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) Has a constitution and bylaws; and

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

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

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

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

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

(i) A group health plan;

(ii) A health benefit plan;

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

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

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

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

(vii) A state health benefits risk pool;

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

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

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

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

(j) "Dependent" means a spouse, ~~an unmarried~~ child under the age ~~of nineteen (19)~~ twenty-six (26) years, ~~an unmarried child who is a student under the age of twenty-five (25) years,~~ and an unmarried child of any age who is financially dependent upon, the parent and is medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

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

(l) [Deleted by P.L. 2006, ch. 258, section 2, and P.L. 2006, ch. 296, section 2.]

(m) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the

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

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

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

(p) "Family composition" means:

(1) Enrollee;

(2) Enrollee, spouse and children;

(3) Enrollee and spouse; or

(4) Enrollee and children.

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

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

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

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

(2) For purposes of this chapter:

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

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

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

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

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

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

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

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

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

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

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

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

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

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

(i) Limited scope dental or vision benefits;

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

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

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

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

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

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

(1) Health status;

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

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

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

(8) Disability.

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

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

(i) Who meets each of the following provisions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

combination of the foregoing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

paragraph.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

carrier for the reasonable cost of disclosing the information.

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

(j) A group health plan and a health insurance carrier offering group health insurance coverage in connection with a group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of an employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if each of the following conditions are met:

(1) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

(2) The employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or carrier (if applicable) required a statement at the time and provided the employee with notice of that requirement (and the consequences of the requirement) at the time;

(3) The employee's or dependent's coverage described in subsection (j)(1):

(i) Was under a COBRA continuation provision and the coverage under that provision was exhausted; or

(ii) Was not under a continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated; and

(4) Under the terms of the plan, the employee requests enrollment not later than thirty (30) days after the date of exhaustion of coverage described in paragraph (3)(i) of this subsection or termination of coverage or employer contribution described in paragraph (3)(ii) of this subsection.

(k) (1) If a group health plan makes coverage available with respect to a dependent of an individual, the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and a person becomes a dependent of the individual through marriage, birth, or adoption or placement through adoption, the group health plan shall provide for a dependent special enrollment period during which the person (or, if not

enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is eligible for coverage.

(2) A dependent special enrollment period shall be a period of not less than thirty (30) days and shall begin on the later of:

(i) The date dependent coverage is made available; or

(ii) The date of the marriage, birth, or adoption or placement for adoption (as the case may be).

(3) If an individual seeks to enroll a dependent during the first thirty (30) days of a dependent special enrollment period, the coverage of the dependent shall become effective:

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

(ii) In the case of a dependent's birth, as of the date of the birth; or

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

(l) (1) A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for the coverage option, but only if that period is applied uniformly without regard to any health status-related factors, and the period does not exceed two (2) months (or three (3) months in the case of a late enrollee).

(2) For the purposes of this subsection, an affiliation shall begin on the enrollment date.

(3) An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(4) The director may approve alternative methods from those described under this subsection to address adverse selection.

(m) For the purpose of determining creditable coverage pursuant to this chapter, no period before July 1, 1996, shall be taken into account. Individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have the coverage credited but for the prohibition in the preceding sentence may be given credit for creditable coverage for those periods through the presentation of documents or other means in accordance with any rule or regulation that may be established by the secretary of the United States Department of Health and Human Services.

(n) In the case of an individual who seeks to establish creditable coverage for any period

for which certification is not required because it relates to an event occurring before June 30, 1996, the individual may present other credible evidence of coverage in order to establish the period of creditable coverage. The group health plan and a health insurance carrier shall not be subject to any penalty or enforcement action with respect to the plan's or carrier's crediting (or not crediting) the coverage if the plan or carrier has sought to comply in good faith with the applicable requirements of this section.

(o) Notwithstanding the provisions of any general or public law to the contrary, for plan or policy years beginning on and after January 1, 2014, a group health plan and a health insurance carrier offering group health insurance coverage shall not deny, exclude, or limit benefits with respect to a participant or beneficiary because of a preexisting condition exclusion.

SECTION. 13 Applicability and Construction.

(a) This act shall apply only to health insurance policies, subscriber contracts, and any other health benefit contract issued on and after July 1, 2012 notwithstanding any other provision of this act.

(b) In its construction and enforcement of the provisions of this act, and in the interests of promoting uniform national rules for health insurance carriers, the office of the health insurance commissioner shall give due deference to the construction, enforcement policies, and guidance of the federal government with respect to federal law substantially similar to the provisions of this act.

SECTION 14. Sections 27-18-36, 27-18-36.1, 27-18-36.2 and 27-18-36.3 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" are hereby repealed on the effective date of RI General Law 27-18-80.

~~**27-18-36. New cancer therapies -- Under investigation.** -- Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state, except policies which only provide coverage for specified diseases other than cancer, fixed indemnity, disability income, accident only, long-term care Medicare supplement limited benefit health, sickness or bodily injury or death by accident or both, or other limited benefit policies, shall provide coverage for new cancer therapies still under investigation as outlined in this chapter.~~

~~**27-18-36.1. "Reliable evidence" defined.** -- "Reliable evidence" means:~~

~~(1) Evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature;~~

~~(2) A written informed consent used by the treating facility or by another facility studying substantially the same service; or~~

~~(3) A written protocol or protocols used by the treating facility or protocols of another facility studying substantially the same service.~~

~~**27-18-36.2. Conditions of coverage.** – As provided in section 27-18-36, coverage shall be extended to new cancer therapies still under investigation when the following circumstances are present:~~

~~(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI), Community clinical oncology programs; the Food and Drug Administration in the form of an Investigational New Drug (IND) exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;~~

~~(2) The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);~~

~~(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;~~

~~(4) The patients receiving the investigational treatment meet all protocol requirements;~~

~~(5) There is no clearly superior, noninvestigational alternative to the protocol treatment;~~

~~(6) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the noninvestigational alternative; and~~

~~(7) The coverage of new cancer therapy treatment provided pursuant to a Phase II clinical trial shall not be required for only that portion of that treatment provided as part of the phase II clinical trial and is otherwise funded by a national agency, such as the National Cancer Institute, the Veteran's Administration, the Department of Defense, or funded by commercial organizations such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any portions of a Phase II trial which are customarily funded by government, biotechnical and/or pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall continue to be so funded in Rhode Island and coverage pursuant to this section shall supplement, not supplant, customary funding.~~

~~**27-18-36.3. Managed care.** – Nothing in this chapter shall preclude the conducting of managed care reviews and medical necessity reviews by an insurer, hospital or medical service corporation, or health maintenance organization.~~

SECTION 15. Sections 27-19-32, 27-19-32.1, 27-19-32.2 and 27-19-32.3 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" are hereby repealed on the effective date of RI General Law 27-19-64.

~~**27-19-32. New cancer therapies -- Under investigation.** -- Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state shall provide coverage for new cancer therapies still under investigation as outlined in this chapter.~~

~~**27-19-32.1. "Reliable evidence" defined.** -- "Reliable evidence" means:~~

~~(1) Evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature;~~

~~(2) A written informed consent used by the treating facility or by another facility studying substantially the same service; or~~

~~(3) A written protocol or protocols used by the treating facility or protocols of another facility studying substantially the same service.~~

~~**27-19-32.2. Conditions of coverage.** -- As provided in section 27-19-32, coverage shall be extended to new cancer therapies still under investigation when the following circumstances are present:~~

~~(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI), community clinical oncology programs; the Food and Drug Administration in the form of an investigation new drug (IND) exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;~~

~~(2) The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);~~

~~(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;~~

~~(4) The patients receiving the investigational treatment meet all protocol requirements;~~

~~(5) There is no clearly superior, noninvestigational alternative to the protocol treatment;~~

~~(6) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the noninvestigational alternative; and~~

~~(7) The coverage of new cancer therapy treatment provided pursuant to a phase II clinical trial shall not be required for that portion of that treatment that is provided as part of the phase II clinical trial and is funded by a national agency, such as the National Cancer Institute, the Veteran's Administration, the Department of Defense, or funded by commercial organizations such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any portions of a phase II trial which are customarily funded by government, biotechnical and/or~~

~~pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall continue to be funded in Rhode Island and coverage pursuant to this section shall supplement, not supplant, customary funding.~~

~~**27-19-32.3. Managed care.** -- Nothing in this chapter shall preclude the conducting of managed care reviews and medical necessity reviews by an insurer, hospital or medical service corporation, or health maintenance corporation.~~

SECTION 16. Sections 27-20-27, 27-20-27.1, 27-20-27.2 and 27-20-27.3 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" are hereby repealed on the effective date of RI General Law 27-20-64.

~~**27-20-27. New cancer therapies -- Under investigation.** -- Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state shall provide coverage for new cancer therapies still under investigation as outlined in this chapter.~~

~~**27-20-27.1. "Reliable evidence" defined.** -- "Reliable evidence" means:~~

~~(1) Evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature;~~

~~(2) A written informed consent used by the treating facility or by another facility studying substantially the same service; or~~

~~(3) A written protocol or protocols used by the treating facility or protocols of another facility studying substantially the same service.~~

~~**27-20-27.2. Conditions of coverage.** -- As provided in section 27-20-27, coverage shall be extended to new cancer therapies still under investigation when the following circumstances are present:~~

~~(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI), community clinical oncology programs; the Food and Drug Administration in the form of an investigational new drug (IND) exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;~~

~~(2) The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);~~

~~(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;~~

~~(4) The patients receiving the investigational treatment meet all protocol requirements;~~

~~(5) There is no clearly superior, noninvestigational alternative to the protocol treatment;~~

~~(6) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the noninvestigational alternative; and~~

~~(7) The coverage of new cancer therapy treatment provided pursuant to a phase II clinical trial is not required for only that portion of that treatment that is provided as part of the phase II clinical trial and is funded by a national agency, such as the National Cancer Institute, the Veteran's Administration, the Department of Defense, or funded by commercial organizations such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any portions of a phase II trial which are customarily funded by government, biotechnical and/or pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall continue to be funded in Rhode Island and coverage pursuant to this section supplements, does not supplant customary funding.~~

~~**27-20-27.3. Managed care.** -- Nothing in this chapter shall preclude the conducting of managed care reviews and medical necessity reviews by an insurer, hospital or medical service corporation, or health maintenance organization. A nonprofit medical service corporation may, as a condition of coverage, require its members to obtain new cancer therapies still under investigation as outlined in this chapter from providers and facilities designated by the nonprofit medical service corporation to render these new cancer therapies.~~

SECTION 17. Sections 27-41-41, 27-41-41.1, 27-41-41.2 and 27-41-41.3 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" are hereby repealed on the effective date of RI General Law 27-41-77.

~~**27-41-41. New cancer therapies -- Under investigation.** -- Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state shall provide coverage for new cancer therapies still under investigation as outlined in this chapter.~~

~~**27-41-41.1. "Reliable evidence" defined.** -- "Reliable evidence" means:~~

~~(1) Evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature;~~

~~(2) A written informed consent used by the treating facility or by another facility studying substantially the same service; or~~

~~(3) A written protocol or protocols used by the treating facility or protocols of another facility studying substantially the same service.~~

~~**27-41-41.2. Conditions of coverage.** -- As provided in section 27-41-41, coverage shall be extended to new cancer therapies still under investigation when the following circumstances~~

~~are present:~~

~~(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI), community clinical oncology programs; the food and drug administration in the form of an investigational new drug (IND) exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;~~

~~(2) The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);~~

~~(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;~~

~~(4) The patients receiving the investigational treatment meet all protocol requirements;~~

~~(5) There are no clearly superior, noninvestigational alternatives to the protocol treatment;~~

~~(6) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the noninvestigational alternative; and~~

~~(7) The coverage of new cancer therapy treatment provided pursuant to a phase II clinical trial is not required for only the portion of that treatment that is provided as part of the phase II clinical trial and is funded by a national agency, such as the National Cancer Institute, the Veteran's Administration, the Department of Defense, or funded by commercial organizations such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any portions of a phase II trial which are customarily funded by government, biotechnical and/or pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall continue to be funded in Rhode Island and coverage pursuant to this section supplements, but does not supplant, that customary funding.~~

~~**27-41-41.3. Managed care.** — Nothing in this chapter shall preclude the conducting of managed care reviews and medical necessity reviews by an insurer, hospital or medical service corporation, or health maintenance organization. A health maintenance organization may as a condition of coverage require its members to obtain these new cancer therapies still under investigation from providers and facilities designated by the health maintenance organization to render these new cancer therapies.~~

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

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This act would establish health insurance standards consistent with the health insurance standards established in the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010. These rules and standards would include, but are not limited to, prohibitions on rescission of coverage, discrimination in coverage, and prohibitions on annual and lifetime limits of coverage unless such limits meet set minimum amounts, as well as adding definitions to the chapters covering health insurance. Specific provisions of this act shall not be enforced by the commissioner of the RI Office of the Health Insurance Commissioner in the event that corresponding sections of the Patient Protection and Affordable Care Act are repealed or found invalid.

This act would take effect upon passage.

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LC02084/SUB A/2
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