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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. 2013

A N A C T

RELATING TO INSURANCE -- GENDER RATING

Introduced By: Senators Sosnowski, Miller, Nesselbush, Cool Rumsey, and Gallo

Date Introduced: February 06, 2013

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 27-18 of the General Laws entitled "Accident and Sickness Insurance Policies" is hereby amended by adding thereto the following section:

27-18-79. Gender rating. – (a) Effective January 1, 2014, no individual or small group health insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical coverage that includes coverage for physician services in a physician's office, and no policy which provides major medical and/or similar comprehensive-type coverage, excluding policies listed in (c), shall vary the premium rate for a health coverage plan based on the gender of the individual policy holders, enrollees, subscribers, or members.

(b) Effective April 1, 2015, no large group health insurance employer contract, plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical coverage that includes coverage for physician services in a physician's office and any policy which provides major medical and/or similar comprehensive-type coverage, excluding policies listed in (c), shall vary the premium rate based on the gender of the individual policy holders, enrollees, subscribers, or members in any one age group.

(c) This section shall not apply to insurance coverage providing benefits for any of the following:

(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;

(8) Sickness of bodily injury or death by accident or both;

(9) Other limited benefit policies.

SECTION 2. Chapter 27-19 of the General Laws entitled "Nonprofit Hospital Service Corporations" is hereby amended by adding thereto the following section:

27-19-70. Gender rating. -- (a) Effective January 1, 2014, no individual or small group health insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical coverage that includes coverage for physician services in a physician's office, and no policy which provides major medical and/or similar comprehensive-type coverage, excluding policies listed in (c), shall vary the premium rate for a health coverage plan based on the gender of the individual policy holders, enrollees, subscribers, or members.

(b) Effective April 1, 2015, no large group health insurance employer contract, plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical coverage that includes coverage for physician services in a physician's office and any policy which provides major medical and/or similar comprehensive-type coverage, excluding policies listed in (c), shall vary the premium rate based on the gender of the individual policy holders, enrollees, subscribers, or members in any one age group.

(c) This section shall not apply to insurance coverage providing benefits for any of the following:

(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;

(8) Sickness of bodily injury or death by accident or both;

(9) Other limited benefit policies.

SECTION 3. Chapter 27-20 of the General Laws entitled "Nonprofit Medical Service Corporations" is hereby amended by adding thereto the following section:

27-20-65. Gender rating. -- (a) Effective January 1, 2014, no individual or small group

health insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical coverage that includes coverage for physician services in a physician's office, and no policy which provides major medical and/or similar comprehensive-type coverage, excluding policies listed in (c), shall vary the premium rate for a health coverage plan based on the gender of the individual policy holders, enrollees, subscribers, or members.

(b) Effective April 1, 2015, no large group health insurance employer contract, plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical coverage that includes coverage for physician services in a physician's office and any policy which provides major medical and/or similar comprehensive-type coverage, excluding policies listed in (c), shall vary the premium rate based on the gender of the individual policy holders, enrollees, subscribers, or members in any one age group.

(c) This section shall not apply to insurance coverage providing benefits for any of the following:

(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;

(8) Sickness of bodily injury or death by accident 1 or both;

(9) Other limited benefit policies.

SECTION 4. Chapter 27-41 of the General Laws entitled "Health Maintenance Organizations" is hereby amended by adding thereto the following section:

27-41-83. Gender rating. -- (a) Effective January 1, 2014, no individual or small group health insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical coverage that includes coverage for physician services in a physician's office, and no policy which provides major medical and/or similar comprehensive-type coverage, excluding policies listed in (c), shall vary the premium rate for a health coverage plan based on the gender of the individual policy holders, enrollees, subscribers, or members.

(b) Effective April 1, 2015, no large group health insurance employer contract, plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical coverage that includes coverage for physician services in a physician's office and any policy which provides major medical and/or similar comprehensive-type coverage, excluding policies listed in

(c), shall vary the premium rate based on the gender of the individual policy holders, enrollees, subscribers, or members in any one age group.

(c) This section shall not apply to insurance coverage providing benefits for any of the following:

(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;

(8) Sickness of bodily injury or death by accident or both;

(9) Other limited benefit policies.

SECTION 5. Section 27-50-5 of the General Laws in Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" is hereby amended to read as follows:

27-50-5. Restrictions relating to premium rates. -- (a) Premium rates for health plans subject to this chapter are subject to the following provisions:

(1) Subject to subdivision (2) of this subsection, a small employer carrier shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Age; ~~and~~

(ii) Gender in accordance with sections 27-41-83, 27-20-65. 27-19-70, 27-18-79; and

(iii) Family composition;

(2) The adjustment for age in paragraph (1)(i) of this subsection may not use age brackets smaller than five (5) year increments and these shall begin with age thirty (30) and end with age sixty-five (65).

(3) The small employer carriers are permitted to develop separate rates for individuals age sixty-five (65) or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates are subject to the requirements of this subsection.

(4) For each health benefit plan offered by a carrier, the highest premium rate for each family composition type shall not exceed four (4) times the premium rate that could be charged to a small employer with the lowest premium rate for that family composition.

(5) Premium rates for bona fide associations except for the Rhode Island Builders'

Association whose membership is limited to those who are actively involved in supporting the construction industry in Rhode Island shall comply with the requirements of section 27-50-5.

(6) For a small employer group renewing its health insurance with the same small employer carrier which provided it small employer health insurance in the prior year, the combined adjustment factor for age and gender for that small employer group will not exceed one hundred twenty percent (120%) of the combined adjustment factor for age and gender for that small employer group in the prior rate year.

(b) The premium charged for a health benefit plan may not be adjusted more frequently than annually except that the rates may be changed to reflect:

(1) Changes to the enrollment of the small employer;

(2) Changes to the family composition of the employee; or

(3) Changes to the health benefit plan requested by the small employer.

(c) Premium rates for health benefit plans shall comply with the requirements of this section.

(d) Small employer carriers shall apply rating factors consistently with respect to all small employers. Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans. Two groups that are otherwise identical, but which have different prior year rate factors may, however, have rating factors that produce premiums that differ because of the requirements of subdivision 27-50-5(a)(6). Nothing in this section shall be construed to prevent a group health plan and a health insurance carrier offering health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, including those included in affordable health benefit plans, provided that the resulting rates comply with the other requirements of this section, including subdivision (a)(5) of this section.

The calculation of premium discounts, rebates, or modifications to otherwise applicable copayments or deductibles for affordable health benefit plans shall be made in a manner consistent with accepted actuarial standards and based on actual or reasonably anticipated small employer claims experience. As used in the preceding sentence, "accepted actuarial standards" includes actuarially appropriate use of relevant data from outside the claims experience of small employers covered by affordable health plans, including, but not limited to, experience derived from the large group market, as this term is defined in section 27-18.6-2(19).

(e) For the purposes of this section, a health benefit plan that contains a restricted

network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.

(f) The health insurance commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including regulations that assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design or coverage (not including differences due to the nature of the groups assumed to select particular health benefit plans or separate claim experience for individual health benefit plans) and to ensure that small employer groups with one eligible subscriber are notified of rates for health benefit plans in the individual market.

(g) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that affect changes premium rates;

(2) The provisions relating to renewability of policies and contracts;

(3) The provisions relating to any preexisting condition provision; and

(4) A listing of and descriptive information, including benefits and premiums, about all benefit plans for which the small employer is qualified.

(h) (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer carrier shall file with the commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. The certification shall be in a form and manner, and shall contain the information, specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(3) A small employer carrier shall make the information and documentation described in subdivision (1) of this subsection available to the commissioner upon request. Except in cases of

violations of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(4) For the wellness health benefit plan described in section 27-50-10, the rates proposed to be charged and the plan design to be offered by any carrier shall be filed by the carrier at the office of the commissioner no less than thirty (30) days prior to their proposed date of use. The carrier shall be required to establish that the rates proposed to be charged and the plan design to be offered are consistent with the proper conduct of its business and with the interest of the public. The commissioner may approve, disapprove, or modify the rates and/or approve or disapprove the plan design proposed to be offered by the carrier. Any disapproval by the commissioner of a plan design proposed to be offered shall be based upon a determination that the plan design is not consistent with the criteria established pursuant to subsection 27-50- (b).

(i) The requirements of this section apply to all health benefit plans issued or renewed on or after October 1, 2000.

SECTION 6. 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 amended to read as follows:

27-20-27. ~~New cancer therapies – Under investigation. [Repealed on effective date of section 27-20-64]. --~~ New cancer therapies – Under investigation. [Repealed on effective date of section 27-20-60]. -- 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. [Repealed on effective date of section 27-20-64]. --~~ "Reliable evidence" defined. [Repealed on effective date of section 27-20-60]. --

"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. [Repealed on effective date of section 27-20-~~

~~64.]. --~~**Conditions of coverage. [Repealed on effective date of section 27-20-60.]. --**As provided in § 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. [Repealed on effective date of section 27-20-64.]. --**~~ **Managed care. [Repealed on effective date of section 27-20-60.]. --** 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 7. 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 amended to read as follows:

27-18-36. ~~New cancer therapies – Under investigation. [Repealed on effective date of section 27-18-80.]. --~~ New cancer therapies – Under investigation. [Repealed on effective date of section 27-18-74.]. --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. [Repealed on effective date of section 27-18-80.]. --~~ "Reliable evidence" defined. [Repealed on effective date of section 27-18-74.]. -- "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. [Repealed on effective date of section 27-18-80.]. --~~ Conditions of coverage. [Repealed on effective date of section 27-18-74.]. --As provided in § 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. [Repealed on effective date of section 27-18-80.]~~ Managed care. [Repealed on effective date of section 27-18-74.] --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 8. Section 27-18-71 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" are hereby amended to read as follows:

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.~~

"Preexisting condition exclusion" means: with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(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 9. Section 27-18.5-10 of the General Laws in Chapter 27-18.5 entitled "Individual Health Insurance Coverage" are hereby amended to read as follows:

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.~~

"Preexisting condition exclusion" means: with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(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 10. Section 27-19-68 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" are hereby amended to read as follows:

27-19-68. Prohibition 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.~~

"Preexisting condition exclusion" means: with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(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. Section 27-20-57 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" are hereby amended to read as follows:

27-20-57. Prohibition 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.~~

"Preexisting condition exclusion" means: with respect to coverage, a limitation or

exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(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 12. Section 27-41-81 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" are hereby amended to read as follows:

27-41-81. Prohibition 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.~~

"Preexisting condition exclusion" means: with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis,

care, or treatment was recommended or received before such date.

(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 13. 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, child under the age twenty-six (26) 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.~~: with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(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. Notwithstanding any provision of this section or of any general or public law to the contrary, ~~With~~ 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 14. 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 this section, or 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 15. This act shall take effect upon passage.

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LC00740/SUB A
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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- GENDER RATING

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This act would provide that insurance companies shall not vary the premium rates charged for a health coverage plan based on the gender of the individual policy holder, enrollee, subscriber, or member.

This act would take effect upon passage.

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LC00740/SUB A
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