

2019 -- H 5916

=====
LC002242
=====

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2019

—————
A N A C T

RELATING TO INSURANCE -- HEALTH INSURANCE COVERAGE--MARKET
STABILITY AND CONSUMER PROTECTION ACT

Introduced By: Representatives McNamara, Bennett, Casimiro, Kazarian, and Kislak

Date Introduced: March 28, 2019

Referred To: House Finance

It is enacted by the General Assembly as follows:

1 SECTION 1. The general assembly hereby finds and declares that:

2 (1) Rhode Island has made significant health insurance coverage gains since the
3 implementation of the Federal Patient Protection and Affordable Care Act.

4 (2) Recent actions by the federal government threaten the existence of the Federal Patient
5 Protection and Affordable Care Act.

6 (3) In order to address the findings set forth in subsections (1) and (2), the purpose of this
7 act is to set a minimum health insurance standard and protect coverage gains and consumer
8 protections achieved under the Federal Patient Protection and Affordable Care Act in Rhode
9 Island.

10 (4) Nothing in this act shall be construed so as to obligate the state to appropriate funds or
11 codify provisions within the Federal Patient Protection and Affordable Care Act and implement
12 regulations related to the Medicaid program.

13 (5) Nothing in this act shall be construed so as to obligate the state to appropriate funds or
14 make payments to insurance carriers.

15 SECTION 2. Sections 27-18-2.1, 27-18-73 and 27-18-75 of the General Laws in Chapter
16 27-18 entitled "Accident and Sickness Insurance Policies" are hereby amended to read as follows:

17 **27-18-2.1. Uniform explanation of benefits and coverage.**

18 (a) A health insurance carrier shall provide a summary of benefits and coverage

1 explanation and definitions to policyholders and others required by, and at the times and in the
2 format required, by the federal regulations adopted under section 2715 [42 U.S.C. § 300gg-15] of
3 the Public Health Service Act, as amended by the ~~federal~~ Federal Affordable Care Act, provided
4 they remain in effect, but if no longer in effect, the immediately prior version of such authorities
5 shall control. The forms required by this section shall be made available to the commissioner on
6 request. Nothing in this section shall be construed to limit the authority of the commissioner
7 under existing state law.

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

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

20 **27-18-73. Prohibition on annual and lifetime limits.**

21 (a) Annual limits.

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

26 ~~(A) For a plan or policy year beginning after September 22, 2011, but before September~~
27 ~~23, 2012 — one million two hundred fifty thousand dollars (\$1,250,000); and~~

28 ~~(B) For a plan or policy year beginning after September 22, 2012, but before January 1,~~
29 ~~2014 — two million dollars (\$2,000,000).~~

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

33 ~~(A)~~(1) A health flexible spending arrangement, as defined in Section 106(c)(2)(i) of the
34 Federal Internal Revenue Code, a medical savings account, as defined in section 220 of the

1 federal Internal Revenue Code, and a health savings account, as defined in Section 223 of the
2 federal Internal Revenue Code are not subject to the requirements of ~~subdivisions (1) and (2) of~~
3 ~~this subsection~~ this subsection.

4 ~~(B)~~(2) The provisions of this subsection shall not prevent a health insurance carrier and a
5 health benefit plan from placing annual dollar limits for any individual on specific covered
6 benefits that are not essential health benefits to the extent that such limits are otherwise permitted
7 under applicable federal law or the laws and regulations of this state.

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

11 (b) Lifetime limits.

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

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

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

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

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

32 ~~(e) If the commissioner of the office of the health insurance commissioner determines~~
33 ~~that the corresponding provision of the federal Patient Protection and Affordable Care Act has~~
34 ~~been declared invalid by a final judgment of the federal judicial branch or has been repealed by~~

~~an act of Congress, on the date of the commissioner's determination this section shall have its effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this section. Nothing in this subsection shall be construed to limit the authority of the Commissioner to regulate health insurance under existing state law.~~

27-18-75. Medical loss ratio reporting and rebates.

(a) A health insurance carrier offering group or individual health insurance coverage of a health benefit plan, including a grandfathered health plan, shall comply with the provisions of Section 2718 [42 U.S.C. § 300gg-18] of the Public Health Service Act as amended by the federal Affordable Care Act, in accordance with regulations adopted thereunder, and state regulations regarding medical loss ratio consistent with federal law and regulations adopted thereunder, so long as they remain in effect. If any of the authorities are no longer in effect, the immediately prior version of the authorities shall control.

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

SECTION 3. Sections 27-18.5-2, 27-18.5-3, 27-18.5-4, 27-18.5-5, 27-18.5-6 and 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:

27-18.5-2. Definitions.

The following words and phrases as used in this chapter have the following meanings consistent with federal law and regulations adopted thereunder, so long as they remain in effect. If the controlling regulations are no longer in effect, the immediately prior version of the controlling regulations shall govern unless a different meaning is required by the context:

(1) "Actuarial value" means the level of coverage of a plan, determined on the basis that the essential health benefits are provided to a standard population.

(2) "Actuarial value tiers" means one of the four (4) levels of coverage, such that a plan at each level is designed to provide benefits that are actuarially equivalent to a percentage of the full actuarial value of the benefits provided under the plan. The actuarially equivalent levels are sixty percent (60%), seventy percent (70%), eighty percent (80%), and ninety percent (90%), and further adjusted to reflect de minimus variations from those levels.

~~(3)~~(3) "Bona fide association" means, with respect to health insurance coverage offered in this state, an association which:

- (i) Has been actively in existence for at least five (5) years;
- (ii) Has been formed and maintained in good faith for purposes other than obtaining

1 insurance;

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

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

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

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

10 (vii) Has a constitution and bylaws; and

11 (viii) Meets any additional requirements that the ~~director~~ commissioner may prescribe by
12 regulation;

13 ~~(2)~~(4) "COBRA continuation provision" means any of the following:

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

16 (ii) Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of
17 1974, 29 U.S.C. § 1161 et seq., other than Section 609 of that act, 29 U.S.C. § 1169; or

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

20 (5) "Cost sharing" means copayments, deductibles, coinsurance and similar charges
21 imposed on an individual receiving benefits under a health benefit plan. Cost sharing does not
22 include monthly premium payments or charges paid by, or on behalf of, an enrollee for benefits
23 provided outside of a health benefit plan's network.

24 ~~(4)~~(6) "~~Director~~" "Commissioner" means the ~~director of the department of business~~
25 ~~regulation~~ health insurance commissioner;

26 ~~(3)~~(7) "Creditable coverage" has the same meaning as defined in the United States Public
27 Health Service Act, Section 2701(c), 42 U.S.C. § 300gg(c), as added by P.L. 104-191;

28 (8) "Dependent" means a spouse, child under the age of twenty-six (26) years, or an
29 unmarried child of any age who is financially dependent upon the parent and is medically
30 determined to have a physical or mental impairment which can be expected to result in death or
31 which has lasted or can be expected to last for a continuous period of not less than twelve (12)
32 months;

33 ~~(5)~~(9) "Eligible individual" means an individual resident of this state.;

34 ~~(i) For whom, as of the date on which the individual seeks coverage under this chapter,~~

1 ~~the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose~~
2 ~~most recent prior creditable coverage was under a group health plan, a governmental plan~~
3 ~~established or maintained for its employees by the government of the United States or by any of~~
4 ~~its agencies or instrumentalities, or church plan (as defined by the Employee Retirement Income~~
5 ~~Security Act of 1974, 29 U.S.C. § 1001 et seq.);~~

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

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

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

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

18 (10) "Essential health benefits" means the following general categories and services
19 covered within the following categories as defined by the commissioner including, but not be
20 limited to:

21 (i) Ambulatory patient services;

22 (ii) Emergency services;

23 (iii) Hospitalization;

24 (iv) Maternity and newborn care;

25 (v) Mental health and substance use disorder services, including behavioral health
26 treatment;

27 (vi) Prescription drugs;

28 (vii) Rehabilitative and habilitative services and devices;

29 (viii) Laboratory services;

30 (ix) Preventive services, wellness services and chronic disease management; and

31 (x) Pediatric services, including oral and vision care.

32 ~~(6)(11) "Group health plan" means an employee welfare benefit plan as defined in section~~
33 ~~3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), to the extent~~
34 ~~that the plan provides medical care and including items and services paid for as medical care to~~

1 employees or their dependents as defined under the terms of the plan directly or through
2 insurance, reimbursement or otherwise;

3 ~~(7)~~(12) "Health insurance carrier" or "carrier" means any entity subject to the insurance
4 laws and regulations of this state, or subject to the jurisdiction of the ~~director~~ [commissioner](#), that
5 contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the
6 costs of health care services, including, without limitation, an insurance company offering
7 accident and sickness insurance, a health maintenance organization, a nonprofit hospital, medical
8 or dental service corporation, or any other entity providing a plan of health insurance or health
9 benefits by which health care services are paid or financed for an eligible individual or his or her
10 dependents by such entity on the basis of a periodic premium, paid directly or through an
11 association, trust, or other intermediary, and issued, renewed, or delivered within or without
12 Rhode Island to cover a natural person who is a resident of this state, including a certificate issued
13 to a natural person which evidences coverage under a policy or contract issued to a trust or
14 association;

15 ~~(8)~~(13)(i) "Health insurance coverage" means a policy, contract, certificate, or agreement
16 offered by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of
17 the costs of health care services.

18 (ii) "Health insurance coverage" does not include one or more, or any combination of, the
19 following [if coverage complies with all other applicable state and federal regulations for limited](#)
20 [or excepted benefits](#):

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

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

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

26 (D) Workers' compensation or similar insurance;

27 (E) Automobile medical payment insurance;

28 (F) Credit-only insurance;

29 (G) Coverage for on-site medical clinics;

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

33 (I) Short term limited duration insurance [in accordance with regulations adopted by the](#)
34 [commissioner](#);

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

4 (A) Limited scope dental or vision benefits;

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

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

9 (iv) "Health insurance coverage" does not include the following benefits if the benefits
10 are provided under a separate policy, certificate, or contract of insurance, there is no coordination
11 between the provision of the benefits and any exclusion of benefits under any group health plan
12 maintained by the same plan sponsor, and the benefits are paid with respect to an event without
13 regard to whether benefits are provided with respect to the event under any group health plan
14 maintained by the same plan sponsor if coverage complies with all other applicable state and
15 federal regulations for limited or excepted benefits:

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

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

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

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

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

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

24 ~~(14)~~ "Health status-related factor" means and includes, but is not limited to, any of the
25 following factors:

26 (i) Health status;

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

28 (iii) Claims experience;

29 (iv) Receipt of health care;

30 (v) Medical history;

31 (vi) Genetic information;

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

34 (viii) Disability;

1 ~~(10)~~(15) "Individual market" means the market for health insurance coverage offered to
2 individuals other than in connection with a group health plan;

3 ~~(11)~~(16) "Network plan" means health insurance coverage offered by a health insurance
4 carrier under which the financing and delivery of medical care including items and services paid
5 for as medical care are provided, in whole or in part, through a defined set of providers under
6 contract with the carrier;

7 ~~(12)~~(17) "Preexisting condition exclusion" means, with respect to health insurance
8 coverage, ~~a condition (whether physical or mental), regardless of the cause of the condition, that~~
9 ~~was present before the date of enrollment for the coverage, for which medical advice, diagnosis,~~
10 ~~care, or treatment was recommended or received within the six (6) month period ending on the~~
11 ~~enrollment date. Genetic information shall not be treated as a preexisting condition in the absence~~
12 ~~of a diagnosis of the condition related to that information; and~~ a limitation or exclusion of
13 benefits (including a denial of coverage) based on the fact that the condition was present before
14 the effective date of coverage (or if coverage is denied, the date of the denial), whether or not any
15 medical advice, diagnosis, care, or treatment was recommended or received before that day. A
16 preexisting condition exclusion includes any limitation or exclusion of benefits (including a
17 denial of coverage) applicable to an individual as a result of information relating to an
18 individual's health status before the individual's effective date of coverage (or if coverage is
19 denied, the date of the denial), such as a condition identified as a result of a pre-enrollment
20 questionnaire or physical examination given to the individual, or review of medical records
21 relating to the pre-enrollment period.

22 ~~(13) "High risk individuals" means those individuals who do not pass medical~~
23 ~~underwriting standards, due to high health care needs or risks;~~

24 ~~(14) "Wellness health benefit plan" means that health benefit plan offered in the~~
25 ~~individual market pursuant to § 27-18.5-8; and~~

26 ~~(15) "Commissioner" means the health insurance commissioner.~~

27 (18) "Preventive services" means those services described in 42 U.S.C. § 300gg-13 and
28 implementing regulations and guidance, and shall be covered without any cost-sharing for the
29 enrollee when delivered by in-network providers, as those terms and obligations are therein
30 described, and if no longer in effect, then the preventive services as may be described in 26
31 U.S.C. § 223 relating to the Internal Revenue Service high deductible health plan safe harbor
32 rules in place as of January 1, 2019. The commissioner shall determine which federally-
33 recommended evidence-based services qualify as preventive care to the extent that federal
34 recommendations change after January 1, 2019.

1 **27-18.5-3. Guaranteed availability to certain individuals.**

2 (a) ~~Notwithstanding any of the provisions of this title to the contrary~~ Subject to
3 subsections (b) through (g) of this section, all health insurance carriers that offer health insurance
4 coverage in the individual market in this state shall provide for the guaranteed availability of
5 coverage to an eligible individual ~~or an individual who has had health insurance coverage,~~
6 ~~including coverage in the individual market, or coverage under a group health plan or coverage~~
7 ~~under 5 U.S.C. § 8901 et seq. and had that coverage continuously for at least twelve (12)~~
8 ~~consecutive months and who applies for coverage in the individual market no later than sixty-~~
9 ~~three (63) days following termination of the coverage, desiring to enroll in individual health~~
10 ~~insurance coverage, and who is not eligible for coverage under a group health plan, part A or part~~
11 ~~B or title XVIII of the Social Security Act, 42 U.S.C. § 1395e et seq. or 42 U.S.C. § 1395j et seq.,~~
12 ~~or any state plan under title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (or any~~
13 ~~successor program) and does not have other health insurance coverage (provided, that eligibility~~
14 ~~for the other coverage shall not disqualify an individual with twelve (12) months of consecutive~~
15 ~~coverage if that individual applies for coverage in the individual market for the primary purpose~~
16 ~~of obtaining coverage for a specific pre-existing condition, and the other available coverage~~
17 ~~excludes coverage for that pre-existing condition) and. A carrier offering health insurance~~
18 coverage in the individual market must offer to any eligible individual in the state all health
19 insurance coverage plans of that carrier that are approved for sale in the individual market, and
20 must accept any eligible individual that applies for coverage under those plans. A carrier may not:

- 21 (1) Decline to offer the coverage to, or deny enrollment of, the individual; or
22 (2) Impose any preexisting condition exclusion with respect to the coverage.

23 (b)~~(1)~~ All health insurance carriers that offer health insurance coverage in the individual
24 market in this state shall offer, to all eligible individuals, all policy forms of health insurance
25 coverage. Such policies shall offer coverage of essential health benefits and shall offer plans in
26 accordance with the actuarial value tiers. A carrier may offer plans with reduced cost sharing for
27 eligible individuals, based on available federal funds as described by 42 U.S.C. § 18071, or based
28 on a program established with state funds. ~~Provided, the carrier may elect to limit the coverage~~
29 ~~offered so long as it offers at least two (2) different policy forms of health insurance coverage~~
30 ~~(policy forms which have different cost sharing arrangements or different riders shall be~~
31 ~~considered to be different policy forms) both of which:~~

- 32 (i) ~~Are designed for, made generally available to, and actively market to, and enroll both~~
33 ~~eligible and other individuals by the carrier; and~~
34 (ii) ~~Meet the requirements of subparagraph (A) or (B) of this paragraph as elected by the~~

1 ~~carrier:~~

2 ~~(A) If the carrier offers the policy forms with the largest, and next to the largest, premium~~
3 ~~volume of all the policy forms offered by the carrier in this state; or~~

4 ~~(B) If the carrier offers a choice of two (2) policy forms with representative coverage,~~
5 ~~consisting of a lower level coverage policy form and a higher level coverage policy form each of~~
6 ~~which includes benefits substantially similar to other individual health insurance coverage offered~~
7 ~~by the carrier in this state and each of which is covered under a method that provides for risk~~
8 ~~adjustment, risk spreading, or financial subsidization.~~

9 ~~(2) For the purposes of this subsection, "lower level coverage" means a policy form for~~
10 ~~which the actuarial value of the benefits under the coverage is at least eighty five percent (85%)~~
11 ~~but not greater than one hundred percent (100%) of the policy form weighted average.~~

12 ~~(3) For the purposes of this subsection, "higher level coverage" means a policy form for~~
13 ~~which the actuarial value of the benefits under the coverage is at least fifteen percent (15%)~~
14 ~~greater than the actuarial value of lower level coverage offered by the carrier in this state, and the~~
15 ~~actuarial value of the benefits under the coverage is at least one hundred percent (100%) but not~~
16 ~~greater than one hundred twenty percent (120%) of the policy form weighted average.~~

17 ~~(4) For the purposes of this subsection, "policy form weighted average" means the~~
18 ~~average actuarial value of the benefits provided by all the health insurance coverage issued (as~~
19 ~~elected by the carrier) either by that carrier or, if the data are available, by all carriers in this state~~
20 ~~in the individual market during the previous year (not including coverage issued under this~~
21 ~~subsection), weighted by enrollment for the different coverage. The actuarial value of benefits~~
22 ~~shall be calculated based on a standardized population and a set of standardized utilization and~~
23 ~~cost factors.~~

24 ~~(5) The carrier elections under this subsection shall apply uniformly to all eligible~~
25 ~~individuals in this state for that carrier. The election shall be effective for policies offered during~~
26 ~~a period of not shorter than two (2) years.~~

27 (c)(1) A carrier may deny health insurance coverage in the individual market to an
28 eligible individual if the carrier has demonstrated to the ~~director~~ [commissioner](#) that:

29 (i) It does not have the financial reserves necessary to underwrite additional coverage;
30 and

31 (ii) It is applying this subsection uniformly to all individuals in the individual market in
32 this state consistent with applicable state law and without regard to any health status-related
33 factor of the individuals and without regard to whether the individuals are eligible individuals.

34 (2) A carrier upon denying individual health insurance coverage in this state in

1 accordance with this subsection may not offer that coverage in the individual market in this state
2 for a period of one hundred eighty (180) days after the date the coverage is denied or until the
3 carrier has demonstrated to the ~~director~~ commissioner that the carrier has sufficient financial
4 reserves to underwrite additional coverage, whichever is later.

5 ~~(d) Nothing in this section shall be construed to require that a carrier offering health
6 insurance coverage only in connection with group health plans or through one or more bona fide
7 associations, or both, offer health insurance coverage in the individual market.~~

8 ~~(e)~~(d) A carrier offering health insurance coverage in connection with group health plans
9 under this title shall not be deemed to be a health insurance carrier offering individual health
10 insurance coverage solely because the carrier offers a conversion policy.

11 (e) A carrier shall develop its rates based on an adjusted community rate and may only
12 vary the adjusted community rate for age. The age of an enrollee shall be determined as of the
13 date of plan issuance or renewal. For each health benefit plan offered by a carrier, the premium
14 rate for the sixty-four (64) years of age or older bracket shall not exceed three (3) times the rate
15 for a twenty-one (21) year old.

16 (f) ~~Except for any high risk pool rating rules to be established by the Office of the Health
17 Insurance Commissioner (OHIC) as described in this section, nothing~~ Nothing in this section
18 shall be construed to ~~create additional restrictions on the amount of premium rates that a carrier
19 may charge an individual for health insurance coverage provided in the individual market; or to
20 prevent a health insurance carrier offering health insurance coverage in the individual market
21 from establishing premium rates discounts or rebates or modifying applicable copayments or
22 deductibles in return for adherence to participation in programs of health promotion and or
23 disease prevention provided the application of these discounts, rebates or cost-sharing
24 modifications and the wellness programs satisfy the requirements of federal and state laws and
25 regulations, including, without limitation, nondiscrimination and mental health parity provisions
26 of federal and state laws and regulations.~~

27 (g) OHIC may pursue federal funding in support of the development of a high risk pool
28 program, reinsurance program, a risk adjustment program, or any other program designed to
29 maintain market stability for the individual market, ~~as defined in § 27-18.5-2, contingent upon a
30 thorough assessment of any financial obligation of the state related to the receipt of said federal
31 funding being presented to, and approved by, the general assembly by passage of concurrent
32 general assembly resolution.~~ Such authority includes to work in collaboration with the health
33 benefit exchange and any other state department to develop a waiver application under § 1332 of
34 the Federal Affordable Care Act or successor programs. The components of ~~the high risk pool~~

1 ~~program~~ such programs, including, but not limited to, rating rules, eligibility requirements and
2 administrative processes, shall be designed in accordance with ~~§ 2745 of the Public Health~~
3 ~~Service Act (42 U.S.C. § 300gg-45) also known as the State High Risk Pool Funding Extension~~
4 ~~Act of 2006 and defined in regulations promulgated by the office of the health insurance~~
5 ~~commissioner on or before October 1, 2007~~ federal and state laws and regulations.

6 (h)(1) In the case of a health insurance carrier that offers health insurance coverage in the
7 individual market through a network plan, the carrier may limit the individuals who may be
8 enrolled under that coverage to those who live, reside, or work within the service areas ~~for that~~
9 can be served by the providers and facilities that are participating in the network plan, consistent
10 with state and federal network adequacy requirements; and within the service areas of the plan,
11 deny coverage to individuals if the carrier has demonstrated to the ~~director~~ commissioner that:

12 (i) It will not have the capacity to deliver services adequately to additional individual
13 enrollees because of its obligations to existing group contract holders and enrollees and individual
14 enrollees; and

15 (ii) It is applying this subsection uniformly to individuals without regard to any health
16 status-related factor of the individuals and without regard to whether the individuals are eligible
17 individuals.

18 (2) Upon denying health insurance coverage in any service area in accordance with the
19 terms of this subsection, a carrier may not offer coverage in the individual market within the
20 service area for a period of one hundred eighty (180) days after the coverage is denied.

21 (i) Open enrollment. An eligible individual is entitled to enroll under the terms of the
22 health benefit plan during an open enrollment period held annually for a period to be between
23 thirty (30) and sixty (60) days.

24 **27-18.5-4. Continuation of coverage -- Renewability.**

25 (a) A health insurance carrier that provides individual health insurance coverage to an
26 individual in this state shall renew or continue in force that coverage at the option of the
27 individual.

28 (b) A health insurance carrier may ~~nonrenew~~ non-renew or discontinue health insurance
29 coverage of an eligible individual in the individual market based only on one or more of the
30 following:

31 (1) The eligible individual has failed to pay premiums or contributions in accordance
32 with the terms of the health insurance coverage ~~or the carrier has not received,~~ including terms
33 relating to timely premium payments;

34 (2) The eligible individual has performed an act or practice that constitutes fraud or made

1 an intentional misrepresentation of material fact under the terms of the coverage within two (2)
2 years after the effective date of this chapter or practice. After two (2) years, the carrier may not
3 renew or discontinue under this subsection only if the eligible individual has failed to reimburse
4 the carrier for the costs associated with the fraud or misrepresentation;

5 (3) The carrier is ceasing to offer coverage in accordance with subsections (c) and (d) of
6 this section;

7 (4) In the case of a carrier that offers health insurance coverage in the market through a
8 geographically-restricted network plan, the individual no longer resides, lives, or works in the
9 service area (or in an area for which the carrier is authorized to do business) but only if the
10 coverage is terminated uniformly without regard to any health status-related factor of covered
11 individuals; or

12 (5) In the case of health insurance coverage that is made available in the individual
13 market only through one or more bona fide associations, the membership of the eligible
14 individual in the association (on the basis of which the coverage is provided) ceases but only if
15 the coverage is terminated uniformly and without regard to any health status-related factor of
16 covered individuals.

17 (c) In any case in which a carrier decides to discontinue offering a particular type of
18 health insurance coverage offered in the individual market, coverage of that type may be
19 discontinued only if:

20 (1) The carrier provides notice, to each covered individual provided coverage of this type
21 in the market, of the discontinuation at least ninety (90) days prior to the date of discontinuation
22 of the coverage;

23 (2) The carrier offers to each individual in the individual market provided coverage of
24 this type, the opportunity to purchase any other individual health insurance coverage currently
25 being offered by the carrier for individuals in the market; and

26 (3) In exercising this option to discontinue coverage of this type and in offering the
27 option of coverage under subdivision (2) of this subsection, the carrier acts uniformly without
28 regard to any health status-related factor of enrolled individuals or individuals who may become
29 eligible for the coverage.

30 (d) In any case in which a carrier elects to discontinue offering all health insurance
31 coverage in the individual market in this state, health insurance coverage may be discontinued
32 only if:

33 (1) The carrier provides notice to the ~~director~~ commissioner and to each individual of the
34 discontinuation at least one hundred eighty (180) days prior to the date of the expiration of the

1 coverage; and

2 (2) All health insurance issued or delivered in this state in the market is discontinued and
3 coverage under this health insurance coverage in the market is not renewed.

4 (e) In the case of a discontinuation under subsection (d) of this section, the carrier may
5 not provide for the issuance of any health insurance coverage in the individual market in this state
6 during the five (5) year period beginning on the date the carrier filed its notice with the
7 department to withdraw from the individual health insurance market in this state. This five (5)
8 year period may be reduced to a minimum of three (3) years at the discretion of the health
9 insurance commissioner, based on his/her analysis of market conditions and other related factors.

10 (f) The provisions of subsections (d) and (e) of this section do not apply if, at the time of
11 coverage renewal, a health insurance carrier modifies the health insurance coverage for a policy
12 form offered to individuals in the individual market so long as the modification is consistent with
13 this chapter and other applicable law and effective on a uniform basis among all individuals with
14 that policy form.

15 (g) In applying this section in the case of health insurance coverage made available by a
16 carrier in the individual market to individuals only through one or more associations, a reference
17 to an "individual" includes a reference to the association (of which the individual is a member).

18 **27-18.5-5. Enforcement -- Limitation on actions.**

19 The ~~director~~ [commissioner](#) has the power to enforce the provisions of this chapter in
20 accordance with § 42-14-16 and all other applicable laws.

21 **27-18.5-6. Rules and regulations.**

22 The ~~director~~ [commissioner](#) may promulgate rules and regulations necessary to effectuate
23 the purposes of this chapter. [If provisions of the federal Patient Protection and Affordable Care
24 Act and implementing regulations, corresponding to the provisions of this chapter are no longer
25 in effect, then the commissioner may promulgate regulations reflecting relevant federal law and
26 implementing regulations in effect immediately prior to such authorities no longer being in effect.
27 In the event of such changes to the law and related regulations, the commissioner, in conjunction
28 with the health benefit exchange or other state department, shall report to the general assembly as
29 soon as possible to describe the impact of the change and to make recommendations regarding
30 consumer protections, consumer choices, and stabilization and affordability of the Rhode Island
31 insurance market.](#)

32 **27-18.5-10. Prohibition on preexisting condition exclusions.**

33 (a) A health insurance policy, subscriber contract, or health plan offered, issued, issued
34 for delivery, or issued to cover a resident of this state by a health insurance company licensed

1 pursuant to this title and/or chapter shall not limit or exclude coverage for any individual by
2 imposing a preexisting condition exclusion on that individual.;

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

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

8 ~~(b) As used in this section:~~

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

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

20 ~~(e)~~(b) This section shall not apply to grandfathered health plans providing individual
21 health insurance coverage.

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

26 SECTION 4. Sections 27-18.6-2, 27-18.6-3, 27-18.6-5, 27-18.6-8 and 27-18.6-9 of the
27 General Laws in Chapter 27-18.6 entitled "Large Group Health Insurance Coverage" are hereby
28 amended to read as follows:

29 **27-18.6-2. Definitions.**

30 The following words and phrases as used in this chapter have the following meanings,
31 consistent with federal law and regulations adopted thereunder, so long as they remain in effect.
32 If such authorities are no longer in effect, the immediately prior version of such authorities shall
33 control unless a different meaning is required by the context:

34 ~~(1) "Affiliation period" means a period which, under the terms of the health insurance~~

1 ~~coverage offered by a health maintenance organization, must expire before the health insurance~~
2 ~~coverage becomes effective. The health maintenance organization is not required to provide~~
3 ~~health care services or benefits during the period and no premium shall be charged to the~~
4 ~~participant or beneficiary for any coverage during the period;~~

5 ~~(2)~~(1) "Beneficiary" has the meaning given that term under section 3(8) of the Employee
6 Retirement Security Act of 1974, 29 U.S.C. § 1002(8);

7 ~~(3)~~(2) "Bona fide association" means, with respect to health insurance coverage in this
8 state, an association which:

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

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

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

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

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

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

20 (vii) Has a constitution and bylaws; and

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

22 ~~(4)~~(3) "COBRA continuation provision" means any of the following:

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

25 (ii) Part 6 of subtitle B of title 1 of the Employee Retirement Income Security Act of
26 1974, 29 U.S.C. § 1161 et seq., other than section 609 of that act, 29 U.S.C. § 1169; or

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

29 ~~(5)~~(4) "Creditable coverage" has the same meaning as defined in the United States Public
30 Health Service Act, section 2701(c), 42 U.S.C. § 300gg(c), as added by P.L. 104-191;

31 ~~(6)~~(5) "Church plan" has the meaning given that term under section 3(33) of the
32 Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(33);

33 ~~(7)~~(6) "~~Director~~" "Commissioner" means the ~~director of the department of business~~
34 ~~regulation~~ health insurance commissioner;

1 (7) "Dependent" means a spouse, child under the age twenty-six (26) years, or an
2 unmarried child of any age who is financially dependent upon the parent and is medically
3 determined to have a physical or mental impairment which can be expected to result in death or
4 that has lasted or can be expected to last for a continuous period of not less than twelve (12)
5 months;

6 (8) "Employee" has the meaning given that term under section 3(6) of the Employee
7 Retirement Income Security Act of 1974, 29 U.S.C. § 1002(6);

8 (9) "Employer" has the meaning given that term under section 3(5) of the Employee
9 Retirement Income Security Act of 1974, 29 U.S.C. § 1002(5), except that the term includes only
10 employers of two (2) or more employees;

11 (10) "Enrollment date" means, with respect to an individual covered under a group health
12 plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage
13 or, if earlier, the first day of the waiting period for the enrollment;

14 (11) "Governmental plan" has the meaning given that term under section 3(32) of the
15 Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(32), and includes any
16 governmental plan established or maintained for its employees by the government of the United
17 States, the government of any state or political subdivision of the state, or by any agency or
18 instrumentality of government;

19 (12) "Group health insurance coverage" means, in connection with a group health plan,
20 health insurance coverage offered in connection with that plan;

21 (13) "Group health plan" means an employee welfare benefits plan as defined in section
22 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), to the extent
23 that the plan provides medical care and including items and services paid for as medical care to
24 employees or their dependents as defined under the terms of the plan directly or through
25 insurance, reimbursement or otherwise;

26 (14) "Health insurance carrier" or "carrier" means any entity subject to the insurance laws
27 and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to
28 contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care
29 services, including, without limitation, an insurance company offering accident and sickness
30 insurance, a health maintenance organization, a nonprofit hospital, medical or dental service
31 corporation, or any other entity providing a plan of health insurance, health benefits, or health
32 services;

33 (15)(i) "Health insurance coverage" means a policy, contract, certificate, or agreement
34 offered by a health insurance carrier to provide, deliver, arrange for, pay for, or reimburse any of

1 the costs of health care services. Health insurance coverage does include short-term and
2 catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as
3 otherwise specifically exempted in this definition;

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

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

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

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

11 (D) Workers' compensation or similar insurance;

12 (E) Automobile medical payment insurance;

13 (F) Credit-only insurance;

14 (G) Coverage for on-site medical clinics; and

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

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

21 (A) Limited scope dental or vision benefits;

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

24 (C) Any other similar, limited benefits that are specified in [state and](#) federal regulations
25 ~~issued pursuant to P.L. 104-191~~;

26 (iv) "Health insurance coverage" does not include the following "noncoordinated,
27 excepted benefits" if the benefits [meet state and federal regulations and](#) are provided under a
28 separate policy, certificate, or contract of insurance, there is no coordination between the
29 provision of the benefits and any exclusion of benefits under any group health plan maintained by
30 the same plan sponsor, and the benefits are paid with respect to an event without regard to
31 whether benefits are provided with respect to the event under any group health plan maintained
32 by the same plan sponsor:

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

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

1 (v) "Health insurance coverage" does not include the following "supplemental, excepted
2 benefits" if offered as a separate policy, certificate, or contract of insurance under state and
3 federal regulations:

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

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

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

8 (16) "Health maintenance organization" ("HMO") means a health maintenance
9 organization licensed under chapter 41 of this title;

10 (17) "Health status-related factor" means and includes, but is not limited to, any of the
11 following factors:

12 (i) Health status;

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

14 (iii) Claims experience;

15 (iv) Receipt of health care;

16 (v) Medical history;

17 (vi) Genetic information;

18 (vii) Evidence of insurability, including contributions arising out of acts of domestic
19 violence; and

20 (viii) Disability;

21 (18) "Large employer" means, in connection with a group health plan with respect to a
22 calendar year and a plan year, an employer who employed an average of at least fifty-one (51)
23 employees on business days during the preceding calendar year and who employs at least two (2)
24 employees on the first day of the plan year. In the case of an employer which was not in existence
25 throughout the preceding calendar year, the determination of whether the employer is a large
26 employer shall be based on the average number of employees that is reasonably expected the
27 employer will employ on business days in the current calendar year;

28 (19) "Large group market" means the health insurance market under which individuals
29 obtain health insurance coverage (directly or through any arrangement) on behalf of themselves
30 (and their dependents) through a group health plan maintained by a large employer;

31 (20) "Large group health plan" means health insurance coverage offered to a large
32 employer in the large group market;

33 ~~(20)~~(21) "Late enrollee" means, with respect to coverage under a group health plan, a
34 participant or beneficiary who enrolls under the plan other than during:

1 (i) The first period in which the individual is eligible to enroll under the plan; or

2 (ii) A special enrollment period;

3 ~~(21)~~(22) "Medical care" means amounts paid for:

4 (i) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid
5 for the purpose of affecting any structure or function of the body;

6 (ii) Amounts paid for transportation primarily for and essential to medical care referred to
7 in paragraph (i) of this subdivision; and

8 (iii) Amounts paid for insurance covering medical care referred to in paragraphs (i) and
9 (ii) of this subdivision;

10 ~~(22)~~(23) "Network plan" means health insurance coverage offered by a health insurance
11 carrier under which the financing and delivery of medical care including items and services paid
12 for as medical care are provided, in whole or in part, through a defined set of providers under
13 contract with the carrier;

14 ~~(23)~~(24) "Participant" has the meaning given such term under section 3(7) of the
15 Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(7);

16 ~~(24) "Placed for adoption" means, in connection with any placement for adoption of a
17 child with any person, the assumption and retention by that person of a legal obligation for total
18 or partial support of the child in anticipation of adoption of the child. The child's placement with
19 the person terminates upon the termination of the legal obligation;~~

20 (25) "Plan sponsor" has the meaning given that term under section 3(16)(B) of the
21 Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(16)(B). "Plan sponsor"
22 also includes any bona fide association, as defined in this section;

23 (26) "Preexisting condition exclusion" means, with respect to health insurance coverage,
24 a limitation or exclusion of benefits ~~relating to a condition based on the fact that the condition
25 was present before the date of enrollment for the coverage, whether or not any medical advice,
26 diagnosis, care or treatment was recommended or received before the date~~ (including a denial of
27 coverage) based on the fact that the condition was present before the effective date of coverage
28 (or if coverage is denied, the date of the denial), whether or not any medical advice, diagnosis,
29 care, or treatment was recommended or received before that day. A preexisting condition
30 exclusion includes any limitation or exclusion of benefits (including a denial of coverage)
31 applicable to an individual as a result of information relating to an individual's health status
32 before the individual's effective date of coverage (or if coverage is denied, the date of the denial),
33 such as a condition identified as a result of a pre-enrollment questionnaire or physical
34 examination given to the individual, or review of medical records relating to the pre-enrollment

1 [period](#); and

2 (27) "Waiting period" means, with respect to a group health plan and an individual who is
3 a potential participant or beneficiary in the plan, the period that must pass with respect to the
4 individual before the individual is eligible to be covered for benefits under the terms of the plan.

5 **27-18.6-3. Limitation on preexisting condition exclusion Preexisting conditions.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 ~~carrier for the reasonable cost of disclosing the information.~~

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

7 ~~(j) A group health plan and a health insurance carrier offering group health insurance~~
8 ~~coverage in connection with a group health plan shall permit an employee who is eligible, but not~~
9 ~~enrolled, for coverage under the terms of the plan (or a dependent of an employee if the~~
10 ~~dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under~~
11 ~~the terms of the plan if each of the following conditions are met:~~

12 ~~(1) The employee or dependent was covered under a group health plan or had health~~
13 ~~insurance coverage at the time coverage was previously offered to the employee or dependent;~~

14 ~~(2) The employee stated in writing at the time that coverage under a group health plan or~~
15 ~~health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or~~
16 ~~carrier (if applicable) required a statement at the time and provided the employee with notice of~~
17 ~~that requirement (and the consequences of the requirement) at the time;~~

18 ~~(3) The employee's or dependent's coverage described in subsection (j)(1):~~

19 ~~(i) Was under a COBRA continuation provision and the coverage under that provision~~
20 ~~was exhausted; or~~

21 ~~(ii) Was not under a continuation provision and either the coverage was terminated as a~~
22 ~~result of loss of eligibility for the coverage (including as a result of legal separation, divorce,~~
23 ~~death, termination of employment, or reduction in the number of hours of employment) or~~
24 ~~employer contributions towards the coverage were terminated; and~~

25 ~~(4) Under the terms of the plan, the employee requests enrollment not later than thirty~~
26 ~~(30) days after the date of exhaustion of coverage described in paragraph (3)(i) of this subsection~~
27 ~~or termination of coverage or employer contribution described in paragraph (3)(ii) of this~~
28 ~~subsection.~~

29 ~~(k)(1) If a group health plan makes coverage available with respect to a dependent of an~~
30 ~~individual, the individual is a participant under the plan (or has met any waiting period applicable~~
31 ~~to becoming a participant under the plan and is eligible to be enrolled under the plan but for a~~
32 ~~failure to enroll during a previous enrollment period), and a person becomes a dependent of the~~
33 ~~individual through marriage, birth, or adoption or placement through adoption, the group health~~
34 ~~plan shall provide for a dependent special enrollment period during which the person (or, if not~~

1 ~~enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in~~
2 ~~the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a~~
3 ~~dependent of the individual if the spouse is eligible for coverage.~~

4 ~~(2) A dependent special enrollment period shall be a period of not less than thirty (30)~~
5 ~~days and shall begin on the later of:~~

6 ~~(i) The date dependent coverage is made available; or~~

7 ~~(ii) The date of the marriage, birth, or adoption or placement for adoption (as the case~~
8 ~~may be).~~

9 ~~(3) If an individual seeks to enroll a dependent during the first thirty (30) days of a~~
10 ~~dependent special enrollment period, the coverage of the dependent shall become effective:~~

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

13 ~~(ii) In the case of a dependent's birth, as of the date of the birth; or~~

14 ~~(iii) In the case of a dependent's adoption or placement for adoption, the date of the~~
15 ~~adoption or placement for adoption.~~

16 ~~(1)(1) A health maintenance organization which offers health insurance coverage in~~
17 ~~connection with a group health plan and which does not impose any preexisting condition~~
18 ~~exclusion allowed under subsection (a) of this section with respect to any particular coverage~~
19 ~~option may impose an affiliation period for the coverage option, but only if that period is applied~~
20 ~~uniformly without regard to any health status related factors, and the period does not exceed two~~
21 ~~(2) months (or three (3) months in the case of a late enrollee).~~

22 ~~(2) For the purposes of this subsection, an affiliation shall begin on the enrollment date.~~

23 ~~(3) An affiliation period under a plan shall run concurrently with any waiting period~~
24 ~~under the plan.~~

25 ~~(4) The director may approve alternative methods from those described under this~~
26 ~~subsection to address adverse selection.~~

27 ~~(m) For the purpose of determining creditable coverage pursuant to this chapter, no~~
28 ~~period before July 1, 1996, shall be taken into account. Individuals who need to establish~~
29 ~~creditable coverage for periods before July 1, 1996, and who would have the coverage credited~~
30 ~~but for the prohibition in the preceding sentence may be given credit for creditable coverage for~~
31 ~~those periods through the presentation of documents or other means in accordance with any rule~~
32 ~~or regulation that may be established by the secretary of the United States Department of Health~~
33 ~~and Human Services.~~

34 ~~(n) In the case of an individual who seeks to establish creditable coverage for any period~~

1 ~~for which certification is not required because it relates to an event occurring before June 30,~~
2 ~~1996, the individual may present other credible evidence of coverage in order to establish the~~
3 ~~period of creditable coverage. The group health plan and a health insurance carrier shall not be~~
4 ~~subject to any penalty or enforcement action with respect to the plan's or carrier's crediting (or not~~
5 ~~crediting) the coverage if the plan or carrier has sought to comply in good faith with the~~
6 ~~applicable requirements of this section.~~

7 (e) Notwithstanding the provisions of any general or public law to the contrary, for plan
8 or policy years beginning on and after January 1, 2014, a group health plan and a health insurance
9 carrier offering group health insurance coverage shall not deny, exclude, or limit [coverage or](#)
10 benefits with respect to a participant or beneficiary because of a preexisting condition exclusion.

11 **27-18.6-5. Continuation of coverage -- Renewability.**

12 (a) Notwithstanding any of the provisions of this title to the contrary, a health insurance
13 carrier that offers health insurance coverage in the large group market in this state in connection
14 with a group health plan shall renew or continue in force that coverage at the option of the plan
15 sponsor of the plan.

16 (b) A health insurance carrier may ~~nonrenew~~ [non-renew](#) or discontinue health insurance
17 coverage offered in connection with a group health plan in the large group market based only on
18 one or more of the following:

19 (1) The plan sponsor has failed to pay premiums or contributions in accordance with the
20 terms of the health insurance coverage or the carrier has not received timely premium payments;

21 (2) The plan sponsor has performed an act or practice that constitutes fraud or made an
22 intentional misrepresentation of material fact under the terms of the coverage [within two \(2\) years](#)
23 [from the date of coverage application. After two \(2\) years, the carrier may non-renew under this](#)
24 [subsection only if the plan sponsor has failed to reimburse the carrier for the costs associated with](#)
25 [the fraud or misrepresentation;](#)

26 (3) The plan sponsor has failed to comply with a material plan provision relating to
27 employer contribution or group participation rules, as permitted by the ~~director~~ [commissioner](#)
28 pursuant to rule or regulation;

29 (4) The carrier is ceasing to offer coverage in accordance with subsections (c) and (d) of
30 this section;

31 (5) The ~~director~~ [commissioner](#) finds that the continuation of the coverage would:

32 (i) Not be in the best interests of the policyholders or certificate holders; or

33 (ii) Impair the carrier's ability to meet its contractual obligations;

34 (6) In the case of a health insurance carrier that offers health insurance coverage in the

1 large group market through a [restricted provider](#) network plan, there is no longer any enrollee in
2 connection with that plan who resides, lives, or works in the service area of the carrier (or in an
3 area for which the carrier is authorized to do business); and

4 (7) In the case of health insurance coverage that is made available in the large group
5 market only through one or more bona fide associations, the membership of an employer in the
6 association (on the basis of which the coverage is provided) ceases, but only if the coverage is
7 terminated under this section uniformly without regard to any health status-related factor relating
8 to any covered individual.

9 (c) In any case in which a carrier decides to discontinue offering a particular type of
10 group health insurance coverage offered in the large group market, coverage of that type may be
11 discontinued by the carrier only if:

12 (1) The carrier provides notice of the decision to all affected plan sponsors, participants,
13 and beneficiaries at least ninety (90) days prior to the date of discontinuation of coverage;

14 (2) The carrier offers to each plan sponsor provided coverage of this type in the large
15 group market the option to purchase any other health insurance coverage currently being offered
16 by the carrier to a group health plan in the market; and

17 (3) In exercising this option to discontinue coverage of this type and in offering the
18 option of coverage under ~~subdivision (3) of this~~ subsection [\(c\)\(2\) of this section](#), the carrier acts
19 uniformly without regard to the claims experience of those plan sponsors or any health status-
20 related factor relating to any participants or beneficiaries covered or new participants or
21 beneficiaries who may become eligible for coverage.

22 (d) In any case in which a carrier elects to discontinue offering and to ~~nonrenew~~ [non-](#)
23 [renew](#) all of its health insurance coverage in the large group market in this state, the carrier shall:

24 (1) Provide advance notice to the ~~director~~ [commissioner](#), to the insurance commissioner
25 in each state in which the carrier is licensed, and to each plan sponsor (and participants and
26 beneficiaries covered under that coverage and to the insurance commissioner in each state in
27 which an affected insured individual is known to reside) of the decision at least one hundred
28 eighty (180) days prior to the date of the discontinuation of coverage. Notice to the insurance
29 commissioner shall be provided at least three (3) working days prior to the notice to the affected
30 plan sponsors, participants, and beneficiaries; and

31 (2) Discontinue all health insurance issued or delivered for issuance in this state's large
32 group market and not renew coverage under any health insurance coverage issued to a large
33 employer.

34 (e) In the case of a discontinuation under subsection (d) of this section, the carrier shall

1 be prohibited from the issuance of any health insurance coverage in the large group market in this
2 state for a period of five (5) years from the date of notice to the ~~director~~ [commissioner](#).

3 (f) At the time of coverage renewal, a health insurance carrier may modify the health
4 insurance coverage for a product offered to a group health plan in the large group market.

5 (g) In applying this section in the case of health insurance coverage that is made available
6 by a carrier in the large group market to employers only through one or more associations, a
7 reference to a "plan sponsor" is deemed, with respect to coverage provided to an employer
8 member of the association, to include a reference to that employer.

9 **27-18.6-8. Enforcement -- Limitation on actions.**

10 The ~~director~~ [commissioner](#) has the power to enforce the provisions of this chapter in
11 accordance with § 42-14-16 and all other applicable state law.

12 **27-18.6-9. Rules and regulations.**

13 The ~~director~~ [commissioner](#) may promulgate rules and regulations necessary to effectuate
14 the purposes of this chapter. [If provisions of the federal Patient Protection and Affordable Care
15 Act and implementing regulations, corresponding to the provisions of this chapter, are no longer
16 in effect, then the commissioner may promulgate regulations reflecting relevant federal law and
17 implementing regulations in effect immediately prior to such authorities no longer being in effect.
18 In the event of such changes to the law and related regulations, the commissioner, in conjunction
19 with the health benefit exchange or other state department, shall report to the general assembly as
20 soon as possible to describe the impact of the change and to make recommendations regarding
21 consumer protections, consumer choices, and stabilization and affordability of the Rhode Island
22 insurance market.](#)

23 SECTION 5. Sections 27-19-7.1, 27-19-63 and 27-19-65 of the General Laws in Chapter
24 27-19 entitled "Nonprofit Hospital Service Corporations" are hereby amended to read as follows:

25 **27-19-7.1. Uniform explanation of benefits and coverage.**

26 (a) A nonprofit hospital service corporation shall provide a summary of benefits and
27 coverage explanation and definitions to policyholders and others required by, and at the times and
28 in the format required, by the federal regulations adopted under section 2715 of the Public Health
29 Service Act, as amended by the federal Affordable Care Act [42 U.S.C. § 300gg-15] [so long as
30 they remain in effect. If such authorities are no longer in effect, the immediately prior version of
31 such authorities shall control.](#) The forms required by this section shall be made available to the
32 commissioner on request. Nothing in this section shall be construed to limit the authority of the
33 commissioner under existing state law.

34 (b) The provisions of this section shall apply to grandfathered health plans. This section

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

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

12 **27-19-63. Prohibition on annual and lifetime limits.**

13 (a) Annual limits.

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

18 ~~(A) For a plan or policy year beginning after September 22, 2011, but before September~~
19 ~~23, 2012— one million two hundred fifty thousand dollars (\$1,250,000); and~~

20 ~~(B) For a plan or policy year beginning after September 22, 2012, but before January 1,~~
21 ~~2014— two million dollars (\$2,000,000).~~

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

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

30 ~~(B)~~(2) The provisions of this subsection shall not prevent a health insurance carrier and
31 health benefit plan from placing annual dollar limits for any individual on specific covered
32 benefits that are not essential health benefits to the extent that such limits are otherwise permitted
33 under applicable federal law or the laws and regulations of this state.

34 ~~(3) In determining whether an individual has received benefits that meet or exceed the~~

1 ~~allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier and~~
2 ~~health benefit plan shall take into account only essential health benefits.~~

3 (b) Lifetime limits.

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

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

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

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

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

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

31 **27-19-65. Medical loss ratio reporting and rebates.**

32 (a) A nonprofit hospital service corporation offering group or individual health insurance
33 coverage of a health benefit plan, including a grandfathered health plan, shall comply with the
34 provisions of Section 2718 of the Public Health Service Act as amended by the federal

1 Affordable Care Act [42 U.S.C. § 300gg-18], in accordance with regulations adopted thereunder
2 and state regulations regarding medical loss ratio consistent with federal law and regulations
3 adopted thereunder, so long as they remain in effect. If such authorities are no longer in effect, the
4 immediately prior version of such authorities shall control.

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

8 SECTION 6. Sections 27-20-6.1, 27-20-59 and 27-20-61 of the General Laws in Chapter
9 27-20 entitled "Nonprofit Medical Service Corporations" are hereby amended to read as follows:

10 **27-20-6.1. Uniform explanation of benefits and coverage.**

11 (a) A nonprofit medical service corporation shall provide a summary of benefits and
12 coverage explanation and definitions to policyholders and others required by, and at the times and
13 in the format required, by the federal regulations adopted under section 2715 of the Public Health
14 Service Act, as amended by the federal Affordable Care Act [42 U.S.C. § 300gg-15] so long as
15 they remain in effect. If such authorities are no longer in effect, the immediately prior version of
16 such authorities shall control. The forms required by this section shall be made available to the
17 commissioner on request. Nothing in this section shall be construed to limit the authority of the
18 commissioner under existing state law.

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

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

31 **27-20-59. Annual and lifetime limits.**

32 (a) Annual limits.

33 ~~(1) For plan or policy years beginning prior to January 1, 2014, for any individual, a~~
34 ~~health insurance carrier and health benefit plan subject to the jurisdiction of the commissioner~~

1 ~~under this chapter may establish an annual limit on the dollar amount of benefits that are essential~~
2 ~~health benefits provided the restricted annual limit is not less than the following:~~

3 ~~(A) For a plan or policy year beginning after September 22, 2011, but before September~~
4 ~~23, 2012 — one million two hundred fifty thousand dollars (\$1,250,000); and~~

5 ~~(B) For a plan or policy year beginning after September 22, 2012, but before January 1,~~
6 ~~2014 — two million dollars (\$2,000,000).~~

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

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

15 ~~(B)(2)~~ The provisions of this subsection shall not prevent a health insurance carrier from
16 placing annual dollar limits for any individual on specific covered benefits that are not essential
17 health benefits to the extent that such limits are otherwise permitted under applicable federal law
18 or the laws and regulations of this state.

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

22 (b) Lifetime limits.

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

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

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

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

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

1 ~~apply to grandfathered health plans providing individual health insurance coverage.~~

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

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

16 **27-20-61. Medical loss ratio reporting and rebates.**

17 (a) A nonprofit medical service corporation offering group or individual health insurance
18 coverage of a health benefit plan, including a grandfathered health plan, shall comply with the
19 provisions of Section 2718 of the Public Health Service Act as amended by the federal
20 Affordable Care Act [42 U.S.C. § 300gg-18], in accordance with regulations adopted thereunder
21 and state regulations regarding medical loss ratio consistent with federal law and regulations
22 adopted thereunder, so long as they remain in effect. If such authorities are no longer in effect, the
23 immediately prior version of such authorities shall control.

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

28 SECTION 7. Sections 27-41-29.1, 27-41-76 and 27-41-78 of the General Laws in
29 Chapter 27-41 entitled "Health Maintenance Organizations" are hereby amended to read as
30 follows:

31 **27-41-29.1. Uniform explanation of benefits and coverage.**

32 (a) A health maintenance organization shall provide a summary of benefits and coverage
33 explanation and definitions to policyholders and others required by, and at the times and in the
34 format required, by the federal regulations adopted under section 2715 of the Public Health

1 Service Act, as amended by the federal Affordable Care Act [42 U.S.C. § 300gg-15] so long as
2 they remain in effect. If such authorities are no longer in effect, the immediately prior version of
3 such authorities shall control. The forms required by this section shall be made available to the
4 commissioner on request. Nothing in this section shall be construed to limit the authority of the
5 commissioner under existing state law.

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

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

18 **27-41-76. Prohibition on annual and lifetime limits.**

19 (a) Annual limits.

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

24 ~~(A) For a plan or policy year beginning after September 22, 2011, but before September~~
25 ~~23, 2012 — one million two hundred fifty thousand dollars (\$1,250,000); and~~

26 ~~(B) For a plan or policy year beginning after September 22, 2012, but before January 1,~~
27 ~~2014 — two million dollars (\$2,000,000).~~

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

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

1 ~~subsection~~ subsection (a)(1) of this section.

2 ~~(B)(2)~~ The provisions of this subsection shall not prevent a health maintenance
3 organization from placing annual dollar limits for any individual on specific covered benefits that
4 are not essential health benefits to the extent that such limits are otherwise permitted under
5 applicable federal law or the laws and regulations of this state.

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

9 (b) Lifetime limits.

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

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

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

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

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

30 ~~(e) If the commissioner of the office of the health insurance commissioner determines~~
31 ~~that the corresponding provision of the federal Patient Protection and Affordable Care Act has~~
32 ~~been declared invalid by a final judgment of the federal judicial branch or has been repealed by~~
33 ~~an act of Congress, on the date of the commissioner's determination this section shall have its~~
34 ~~effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this~~

1 ~~section. Nothing in this subsection shall be construed to limit the authority of the Commissioner~~
2 ~~to regulate health insurance under existing state law.~~

3 **27-41-78. Medical loss ratio reporting and rebates.**

4 (a) A health maintenance organization offering group or individual health insurance
5 coverage of a health benefit plan, including a grandfathered health plan, shall comply with the
6 provisions of Section 2718 of the Public Health Service Act as amended by the federal
7 Affordable Care Act [42 U.S.C. § 300gg-18], in accordance with regulations adopted thereunder
8 and state regulations regarding medical loss ratio consistent with federal law and regulations
9 adopted thereunder, so long as they remain in effect. If such authorities are no longer in effect, the
10 immediately prior version of such authorities shall control.

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

14 SECTION 8. Sections 27-50-3, 27-50-4, 27-50-5, 27-50-6, 27-50-7, 27-50-11, 27-50-12
15 and 27-50-15 of the General Laws in Chapter 27-50 entitled "Small Employer Health Insurance
16 Availability Act" are hereby amended to read as follows:

17 **27-50-3. Definitions.**

18 The following words and phrases as used in this chapter have the following meanings
19 consistent with federal law and regulations adopted thereunder, so long as they remain in effect.
20 If such authorities are no longer in effect, the immediately prior version of such authorities shall
21 control unless a different meaning is required by the context:

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

28 (b) "Actuarial value" means the level of coverage of a plan, determined on the basis that
29 the essential health benefits are provided to a standard population.

30 (c) "Actuarial value tiers" means one of the four (4) levels of coverage, such that a plan at
31 each level is designed to provide benefits that are actuarially equivalent to a percentage of the full
32 actuarial value of the benefits provided under the plan. The actuarially equivalent levels are: sixty
33 percent (60%), seventy percent (70%), eighty percent (80%), and ninety percent (90%), and
34 further adjusted to reflect de minimus variations from those levels.

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

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

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

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

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

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

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

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

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

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

23 (7) Has a constitution and bylaws; and

24 (8) Meets any additional requirements that the ~~director~~ commissioner may prescribe by
25 regulation.

26 ~~(h)~~(h) "Carrier" or "small employer carrier" means all entities licensed, or required to be
27 licensed, in this state that offer health benefit plans covering eligible employees of one or more
28 small employers pursuant to this chapter. For the purposes of this chapter, carrier includes an
29 insurance company, a nonprofit hospital or medical service corporation, a fraternal benefit
30 society, a health maintenance organization as defined in chapter 41 of this title or as defined in
31 chapter 62 of title 42, or any other entity subject to state insurance regulation that provides
32 medical care as defined in subsection ~~(y)~~(x) that is paid or financed for a small employer by such
33 entity on the basis of a periodic premium, paid directly or through an association, trust, or other
34 intermediary, and issued, renewed, or delivered within or without Rhode Island to a small

1 employer pursuant to the laws of this or any other jurisdiction, including a certificate issued to an
2 eligible employee which evidences coverage under a policy or contract issued to a trust or
3 association.

4 ~~(e)~~(i) "Church plan" has the meaning given this term under § 3(33) of the Employee
5 Retirement Income Security Act of 1974 [29 U.S.C. § 1002(33)].

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

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

9 (2) Part 6 of subtitle B of title 1 of the Employee Retirement Income Security Act of
10 1974, 29 U.S.C. § 1161 et seq., other than section 609 of that act, 29 U.S.C. § 1169; or

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

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

14 (l) "Cost sharing" means copayments, deductibles, coinsurance and similar charges
15 imposed on an individual receiving benefits under a health benefit plan. Cost sharing shall not
16 include monthly premium payments or charges paid by, or on behalf of, an enrollee for benefits
17 provided outside of a health benefit plan's network.

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

20 (i) A group health plan;

21 (ii) A health benefit plan;

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

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

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

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

33 (vii) A state health benefits risk pool;

34 (viii) A health plan offered under 5 U.S.C. § 8901 et seq., (Federal Employees Health

1 Benefits Program (FEHBP));

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

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

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

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

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

15 ~~(l)~~(o) [Deleted by P.L. 2006, ch. 258, § 2, and P.L. 2006, ch. 296, § 2.]

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

34 ~~(n)~~(q) "Enrollment date" means the first day of coverage or, if there is a waiting period,

1 the first day of the waiting period, whichever is earlier.

2 (r) "Essential health benefits" means the following general categories and the items and
3 services covered within the following categories, as defined by the commissioner including, but
4 not be limited to:

5 (1) Ambulatory patient services;

6 (2) Emergency services;

7 (3) Hospitalization;

8 (4) Maternity and newborn care;

9 (5) Mental health and substance use disorder services, including behavioral health
10 treatment;

11 (6) Prescription drugs;

12 (7) Rehabilitative and habilitative services and devices;

13 (8) Laboratory services;

14 (9) Preventive services, wellness services and chronic disease management;

15 (10) Pediatric services, including oral and vision care;

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

19 ~~(p) "Family composition" means:~~

20 ~~(1) Enrollee;~~

21 ~~(2) Enrollee, spouse and children;~~

22 ~~(3) Enrollee and spouse; or~~

23 ~~(4) Enrollee and children.~~

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

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

32 ~~(u)~~(u)(1) "Group health plan" means an employee welfare benefit plan as defined in §
33 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), to the extent
34 that the plan provides medical care, as defined in subsection ~~(y)~~(x) of this section, and including

1 items and services paid for as medical care to employees or their dependents as defined under the
2 terms of the plan directly or through insurance, reimbursement, or otherwise.

3 (2) For purposes of this chapter:

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

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

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

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

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

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

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

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

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

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

33 (iv) Workers' compensation or similar insurance;

34 (v) Automobile medical payment insurance;

- 1 (vi) Credit-only insurance;
- 2 (vii) Coverage for on-site medical clinics; and
- 3 (viii) Other similar insurance coverage, specified in federal [and state](#) regulations ~~issued~~
4 ~~pursuant to Pub. L. No. 104-191~~, under which benefits for medical care are secondary or
5 incidental to other insurance benefits.

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

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

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

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

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

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

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

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

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

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

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

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

11 ~~(w)~~(w) "Health maintenance organization" or "HMO" means a health maintenance
12 organization licensed under chapter 41 of this title.

13 ~~(x)~~(x) "Health status-related factor" means and includes, but is not limited to, any of the
14 following factors:

- 15 (1) Health status;
- 16 (2) Medical condition, including both physical and mental illnesses;
- 17 (3) Claims experience;
- 18 (4) Receipt of health care;
- 19 (5) Medical history;
- 20 (6) Genetic information;
- 21 (7) Evidence of insurability, including conditions arising out of acts of domestic violence;

22 or

- 23 (8) Disability.

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

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

29 ~~(i) Who meets each of the following provisions:~~

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

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

1 ~~legal separation, or the individual and/or dependents are determined to be eligible for RiteCare~~
2 ~~under chapter 5.1 of title 40 or chapter 12.3 of title 42 or for RiteShare under chapter 8.4 of title~~
3 ~~40; and~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (cc)(1) "Preexisting condition exclusion" means ~~a condition, regardless of the cause of~~
4 ~~the condition, for which medical advice, diagnosis, care, or treatment was recommended or~~
5 ~~received during the six (6) months immediately preceding the enrollment date of the coverage. a~~
6 limitation or exclusion of benefits (including a denial of coverage) based on the fact that the
7 condition was present before the effective date of coverage (or if coverage is denied, the date of
8 the denial), whether or not any medical advice, diagnosis, care, or treatment was recommended or
9 received before that day. A preexisting condition exclusion includes any limitation or exclusion
10 of benefits (including a denial of coverage) applicable to an individual as a result of information
11 relating to an individual's health status before the individual's effective date of coverage (or if
12 coverage is denied, the date of the denial), such as a condition identified as a result of a pre-
13 enrollment questionnaire or physical examination given to the individual, or review of medical
14 records relating to the pre-enrollment period.

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

20 ~~(3)~~(2) Genetic information shall not be treated as a condition under subdivision (1) of this
21 subsection for which a preexisting condition exclusion may be imposed in the absence of a
22 diagnosis of the condition related to the information.

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

26 (ee) "Preventive services" means those services described in 42 U.S.C. section 300gg-13
27 and implementing regulations and guidance, and shall be covered without any cost sharing for the
28 enrollee when delivered by in-network providers, as those terms and obligations are therein
29 described, and if no longer in effect then the preventive services as may be described in 26 U.S.C.
30 section 223 relating to the Internal Revenue Service high deductible health plan safe harbor rules
31 in place as of January 1, 2019. The commissioner shall determine which federally-recommended
32 evidence-based services qualify as preventive care to the extent that federal recommendations
33 change after January 1, 2019.

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

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

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

7 ~~(hh) "Risk adjustment mechanism" means the mechanism established pursuant to § 27-~~
8 ~~50-16.~~

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

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

17 ~~(kk)~~(jj)(1) "Small employer" means, ~~except for its use in § 27-50-7, any person, firm,~~
18 ~~corporation, partnership, association, political subdivision, or self-employed individual that is~~
19 ~~actively engaged in business including, but not limited to, a business or a corporation organized~~
20 ~~under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of~~
21 ~~another state that, on at least fifty percent (50%) of its working days during the preceding~~
22 ~~calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week~~
23 ~~of thirty (30) or more hours, the majority of whom were employed within this state, and is not~~
24 ~~formed primarily for purposes of buying health insurance and in which a bona fide employer-~~
25 ~~employee relationship exists. In determining the number of eligible employees, companies that~~
26 ~~are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation~~
27 ~~by this state, shall be considered one employer. Subsequent to the issuance of a health benefit~~
28 ~~plan to a small employer and for the purpose of determining continued eligibility, the size of a~~
29 ~~small employer shall be determined annually. Except as otherwise specifically provided,~~
30 ~~provisions of this chapter that apply to a small employer shall continue to apply at least until the~~
31 ~~plan anniversary following the date the small employer no longer meets the requirements of this~~
32 ~~definition. The term small employer includes a self-employed individual. to the extent allowed by~~
33 ~~federal law and regulation in connection with a group health plan with respect to a calendar year~~
34 ~~and a plan year, an employer who is a self-employed individual or an entity who employed an~~

1 average of at least one but not more than fifty (50) employees on business days during the
2 preceding calendar year, and is a self-employed individual or an entity who employs at least one
3 employee on the first day of the plan year.

4 (2) Special rules for determining small employer status:

5 (i) Application of aggregation rule for employers. All persons treated as a single
6 employer under subsections (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of
7 1986 (26 U.S.C. §414) shall be treated as a single employer.

8 (ii) Employer not in existence in preceding year. In the case of an employer which was
9 not in existence throughout the preceding calendar year, the determination of whether such
10 employer is a small employer shall be based on the average number of employees that it is
11 reasonably expected such employer will employ on the first day of the plan year.

12 (iii) Predecessors. Any reference in this subsection to an employer shall include a
13 reference to any predecessor of such employer.

14 (iv) Continuation of participation for growing small employers. If:

15 (A) A small employer makes enrollment in qualified health plans offered in the small
16 group market available to its employees through an exchange; and

17 (B) The employer ceases to be a small employer by reason of an increase in the number
18 of employees of such employer, then the employer shall continue to be treated as a small
19 employer for purposes of this chapter for the period beginning with the increase and ending with
20 the first day on which the employer does not make such enrollment available to its employees.

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

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

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

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

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

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

1 **27-50-4. Applicability and scope.**

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

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

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

9 (3) The health benefit plan is treated by the employer or any of the eligible employees or
10 dependents as part of a plan or program for the purposes of Section 162, Section 125, or Section
11 106 of the United States Internal Revenue Code, 26 U.S.C. § 162, 125, or 106; or

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

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

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

21 (3) Unless otherwise authorized by the ~~director~~ commissioner, a small employer carrier
22 shall not enter into one or more ceding arrangements with another carrier with respect to health
23 benefit plans delivered or issued for delivery to small employers in this state if those
24 arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for
25 the health benefit plans being retained by the ceding carrier. The ~~department of business~~
26 ~~regulation's~~ statutory provisions relating to licensing and regulation of licensed insurers under this
27 title shall apply if a small employer carrier cedes or assumes ~~all~~ any material portion of the
28 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
29 for delivery to small employers in this state.

30 **27-50-5. Restrictions relating to premium rates.**

31 (a) Premium rates for health benefit plans subject to this chapter are subject to the
32 following provisions:

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

1 (i) Age;
2 (ii) Gender; and
3 (iii) Family composition; age. The age of an enrollee shall be determined as of the date of
4 plan issuance or renewal.

5 (2) ~~The adjustment for age in paragraph (1)(i) of this subsection may not use age brackets~~
6 ~~smaller than five (5) year increments and these shall begin with age thirty (30) and end with age~~
7 ~~sixty five (65).~~ The small employer carrier shall determine premium rates for a small employer
8 by summing the premium amounts for each covered employee and dependent, in accordance with
9 federal and state laws and regulations.

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

14 (4)(3) For each health benefit plan offered by a carrier, the highest premium rate for each
15 ~~family composition type~~ the sixty-four (64) years of age or older bracket shall not exceed ~~four (4)~~
16 three (3) times the premium rate that could be charged to a small employer ~~with the lowest~~
17 ~~premium rate for that family composition~~ for the rate for a twenty-one (21) year old.

18 (5)(4) Premium rates for bona fide associations except for the Rhode Island Builders'
19 Association whose membership is limited to those who are actively involved in supporting the
20 construction industry in Rhode Island shall comply with the requirements of § 27-50-5 and all
21 other requirements of state law and regulation relating to rates.

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

27 (b)(5) The premium charged for a health benefit plan may not be adjusted more
28 frequently than annually except that the rates may be changed to reflect:

- 29 (1) ~~Changes to the enrollment of the small employer;~~
30 (2) ~~Changes to the family composition of the employee; or~~
31 (3) ~~Changes to the health benefit plan requested by the small employer.~~
32 Changes to the health benefit plan requested by the small employer.

33 (e)(b) Premium rates for health benefit plans shall comply with the requirements of this
34 section.

1 ~~(d)~~(c) Small employer carriers shall apply rating factors consistently with respect to all
2 small employers. Rating factors shall produce premiums for identical groups that differ only by
3 the amounts attributable to plan design, such as different cost sharing or provider network
4 restrictions and do not reflect differences due to the nature of the groups assumed to select
5 particular health benefit plans. ~~Two groups that are otherwise identical, but which have different~~
6 ~~prior year rate factors may, however, have rating factors that produce premiums that differ~~
7 ~~because of the requirements of subdivision 27-50-5(a)(6).~~ Nothing in this section shall be
8 construed to prevent a group health plan and a health insurance carrier offering health insurance
9 coverage from establishing premium discounts or rebates or modifying otherwise applicable
10 copayments or deductibles in return for ~~adherence to~~ participation in programs of health
11 promotion ~~and or~~ or disease prevention, provided the application of these discounts, rebates and cost
12 sharing modifications, and the wellness programs satisfy the requirements of federal and state
13 laws and regulations, including without limitation nondiscrimination and mental health parity
14 provisions of federal and state laws, including those included in affordable health benefit plans,
15 ~~provided that the resulting rates comply with the other requirements of this section, including~~
16 ~~subdivision (a)(5) of this section.~~

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

24 ~~(e)~~(d) For the purposes of this section, a health benefit plan that contains a restricted
25 network provision shall not be considered similar coverage to a health benefit plan that does not
26 contain such a provision, provided that the restriction of benefits to network providers results in
27 substantial differences in claim costs.

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

1 subscriber are notified of rates for health benefit plans in the individual market.

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

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

8 (2) The provisions relating to the availability and renewability of policies and contracts;
9 and

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

11 ~~(4)~~(3) A listing of and descriptive information, including benefits and premiums, about
12 all benefit plans for which the small employer is qualified.

13 ~~(h)~~(1)(g) Each small employer carrier shall maintain at its principal place of business a
14 complete and detailed description of its rating practices and renewal underwriting practices,
15 including information and documentation that demonstrate that its rating methods and practices
16 are based upon commonly accepted actuarial assumptions and are in accordance with sound
17 actuarial principles. Any changes to the carrier's rating and underwriting practices shall be subject
18 to the provisions of §§ 27-18-8, 27-41-27.2, and 42-62-13.

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

25 ~~(3) A small employer carrier shall make the information and documentation described in~~
26 ~~subdivision (1) of this subsection available to the commissioner upon request. Except in cases of~~
27 ~~violations of this chapter, the information shall be considered proprietary and trade secret~~
28 ~~information and shall not be subject to disclosure by the director to persons outside of the~~
29 ~~department except as agreed to by the small employer carrier or as ordered by a court of~~
30 ~~competent jurisdiction.~~

31 ~~(4) For the wellness health benefit plan described in § 27-50-10, the rates proposed to be~~
32 ~~charged and the plan design to be offered by any carrier shall be filed by the carrier at the office~~
33 ~~of the commissioner no less than thirty (30) days prior to their proposed date of use. The carrier~~
34 ~~shall be required to establish that the rates proposed to be charged and the plan design to be~~

1 ~~offered are consistent with the proper conduct of its business and with the interest of the public.~~
2 ~~The commissioner may approve, disapprove, or modify the rates and/or approve or disapprove~~
3 ~~the plan design proposed to be offered by the carrier. Any disapproval by the commissioner of a~~
4 ~~plan design proposed to be offered shall be based upon a determination that the plan design is not~~
5 ~~consistent with the criteria established pursuant to subsection 27-50-10(b).~~

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

8 **27-50-6. Renewability of coverage.**

9 (a) A health benefit plan subject to this chapter is renewable with respect to all eligible
10 employees or dependents, at the option of the small employer, except in any of the following
11 cases:

12 (1) The plan sponsor has failed to pay premiums or contributions in accordance with the
13 terms of the health benefit plan or the carrier has not received timely premium payments;

14 (2) The plan sponsor or, with respect to coverage of individual insured under the health
15 benefit plan, the insured or the insured's representative has performed an act or practice that
16 constitutes fraud or made an intentional misrepresentation of material fact under the terms of
17 coverage and the non-renewal is made within two (2) years after the act or practice. After two (2)
18 years, the carrier may non-renew under this subsection only if the plan sponsor has failed to
19 reimburse the carrier for the costs associated with the fraud or misrepresentation;

20 (3) Noncompliance with the carrier's minimum participation requirements;

21 (4) Noncompliance with the carrier's employer contribution requirements;

22 (5) The small employer carrier elects to discontinue offering all of its health benefit plans
23 delivered or issued for delivery to small employers in this state if the carrier:

24 (i) Provides advance notice of its decision under this paragraph to the commissioner in
25 each state in which it is licensed; and

26 (ii) Provides notice of the decision to:

27 (A) All affected small employers and enrollees and their dependents; and

28 (B) The insurance commissioner in each state in which an affected insured individual is
29 known to reside at least one hundred and eighty (180) days prior to the ~~nonrenewal~~ non-renewal
30 of any health benefit plans by the carrier, provided the notice to the commissioner under this
31 subparagraph is sent at least three (3) working days prior to the date the notice is sent to the
32 affected small employers and enrollees and their dependents;

33 (6) The ~~director~~ commissioner:

34 (i) Finds that the continuation of the coverage would not be in the best interests of the

1 policyholders or certificate holders or would impair the carrier's ability to meet its contractual
2 obligations; and

3 (ii) Assists affected small employers in finding replacement coverage;

4 (7) The small employer carrier decides to discontinue offering a particular type of health
5 benefit plan in the state's small employer market if the carrier:

6 (i) Provides notice of the decision not to renew coverage at least ninety (90) days prior to
7 the ~~nonrenewal~~ non-renewal of any health benefit plans to all affected small employers and
8 enrollees and their dependents;

9 (ii) Offers to each small employer issued a particular type of health benefit plan the
10 option to purchase all other health benefit plans currently being offered by the carrier to small
11 employers in the state; and

12 (iii) In exercising this option to discontinue a particular type of health benefit plan and in
13 offering the option of coverage pursuant to paragraph (7)(ii) of this subsection acts uniformly
14 without regard to the claims experience of those small employers or any health status-related
15 factor relating to any enrollee or dependent of an enrollee or enrollees and their dependents
16 covered or new enrollees and their dependents who may become eligible for coverage;

17 (8) In the case of health benefit plans that are made available in the small group market
18 through a network plan, there is no longer an employee of the small employer living, working or
19 residing within the carrier's established geographic service area and the carrier would deny
20 enrollment in the plan ~~pursuant to § 27-50-7(e)(1)(ii)~~; or

21 (9) In the case of a health benefit plan that is made available in the small employer
22 market only through one or more bona fide associations, the membership of an employer in the
23 bona fide association, on the basis of which the coverage is provided, ceases, but only if the
24 coverage is terminated under this paragraph uniformly without regard to any health status-related
25 factor relating to any covered individual.

26 (b)(1) A small employer carrier that elects not to renew health benefit plan coverage
27 pursuant to subdivision (a)(2) of this section because of the small employer's fraud or intentional
28 misrepresentation of material fact under the terms of coverage may choose not to issue a health
29 benefit plan to that small employer for one year after the date of ~~nonrenewal~~ non-renewal.

30 (2) This subsection shall not be construed to affect the requirements of § 27-50-7 as to the
31 obligations of other small employer carriers to issue any health benefit plan to the small
32 employer.

33 (c)(1) A small employer carrier that elects to discontinue offering health benefit plans
34 under subdivision (a)(5) of this section is prohibited from writing new business in the small

1 employer market in this state for a period of five (5) years beginning on the date ~~the carrier~~
2 ~~ceased offering new coverage in this state~~ of discontinuance of the last coverage not renewed.

3 (2) In the case of a small employer carrier that ceases offering new coverage in this state
4 pursuant to subdivision (a)(5) of this section, the small employer carrier, ~~as determined by the~~
5 ~~director, may renew its existing business in the small employer market in the state or may be~~
6 ~~required to nonrenew~~ shall discontinue and non-renew all of its existing business in the small
7 employer market in the state upon proper notice.

8 (d) A small employer carrier offering coverage through a network plan is not required to
9 offer coverage or accept applications pursuant to subsection (a) or (b) of this section in the case of
10 the following:

11 (1) To an eligible person who no longer resides, lives, or works in the service area, or in
12 an area for which the carrier is authorized to do business, but only if coverage is terminated under
13 this subdivision uniformly without regard to any health status-related factor of covered
14 individuals; or

15 (2) To a small employer that no longer has any enrollee in connection with the plan who
16 lives, resides, or works in the service area of the carrier, or the area for which the carrier is
17 authorized to do business.

18 (e) At the time of coverage renewal, a small employer carrier may modify the health
19 insurance coverage for a product offered to a group health plan if, for coverage that is available in
20 the small group market other than only through one or more bona fide associations, such
21 modification is consistent with otherwise applicable law and effective on a uniform basis among
22 group health plans with that product.

23 **27-50-7. Availability of coverage.**

24 ~~(a) Until October 1, 2004, for purposes of this section, "small employer" includes any~~
25 ~~person, firm, corporation, partnership, association, or political subdivision that is actively~~
26 ~~engaged in business that on at least fifty percent (50%) of its working days during the preceding~~
27 ~~calendar quarter, employed a combination of no more than fifty (50) and no less than two (2)~~
28 ~~eligible employees and part-time employees, the majority of whom were employed within this~~
29 ~~state, and is not formed primarily for purposes of buying health insurance and in which a bona~~
30 ~~fide employer-employee relationship exists. After October 1, 2004, for the purposes of this~~
31 ~~section, "small employer" has the meaning used in § 27-50-3(kk).~~

32 (b)(a)(1) Every small employer carrier shall, as a condition of transacting business in this
33 state with small employers, ~~actively~~ offer to small employers all health benefit plans ~~it actively~~
34 ~~markets~~ that are approved for sale to small employers in this state ~~including a wellness health~~

1 ~~benefit plan. A small employer carrier shall be considered to be actively marketing a health~~
2 ~~benefit plan if it offers that plan to any small employer not currently receiving a health benefit~~
3 ~~plan from the small employer carrier, and must accept any small employer that applies for any of~~
4 ~~those health benefit plans subject to the provisions of this chapter. Such plans shall offer coverage~~
5 ~~of essential health benefits.~~

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

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

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

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

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

26 ~~(2)(i) Except as provided in subdivision (3) of this subsection, a small employer carrier~~
27 ~~shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of~~
28 ~~creditable coverage without regard to the specific benefits covered during the period of creditable~~
29 ~~coverage, provided that the last period of creditable coverage ended on a date not more than~~
30 ~~ninety (90) days prior to the enrollment date of new coverage.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 ~~(7)(i)(c)~~ A small employer carrier shall permit an employee or a dependent of the
8 employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the group
9 health plan of the small employer during a special enrollment period ~~if, as defined by federal and~~
10 state laws and regulations, including, but not limited to, the following situations:

11 ~~(A)(1)~~ The employee or dependent was covered under a group health plan or had
12 coverage under a health benefit plan at the time coverage was previously offered to the employee
13 or dependent;

14 ~~(B)(2)~~ The employee stated in writing at the time coverage was previously offered that
15 coverage under a group health plan or other health benefit plan was the reason for declining
16 enrollment, but only if the plan sponsor or carrier, if applicable, required that statement at the
17 time coverage was previously offered and provided notice to the employee of the requirement and
18 the consequences of the requirement at that time;

19 ~~(C)(3)~~ The employee's or dependent's coverage described under ~~subparagraph (A) of this~~
20 ~~paragraph~~ subsection (c)(2) of this section:

21 ~~(i)~~ Was under a COBRA continuation provision and the coverage under this provision
22 has been exhausted; or

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

27 ~~(D)(4)~~ Under terms of the group health plan, the employee requests enrollment not later
28 than thirty (30) days after the date of exhaustion of coverage described in ~~item (C)(i) of this~~
29 ~~paragraph~~ subsection (c)(3)(i) of this section or termination of coverage or employer contribution
30 described in ~~item (C)(ii) of this paragraph~~ subsection (c)(3)(ii) of this section.

31 ~~(i)(5)~~ If an employee requests enrollment pursuant to ~~subparagraph (i)(D) of this~~
32 ~~subdivision~~ this subsection, the enrollment is effective not later than the first day of the first
33 calendar month beginning after the date the completed request for enrollment is received.

34 ~~(8)(i)(d)(1)~~ A small employer carrier that makes coverage available under a group health

1 plan with respect to a dependent of an individual shall provide for a dependent special enrollment
2 period described in ~~paragraph (ii) of this subdivision~~ [this section](#) during which the person or, if
3 not enrolled, the individual may be enrolled under the group health plan as a dependent of the
4 individual and, in the case of the birth or adoption of a child, the spouse of the individual may be
5 enrolled as a dependent of the individual if the spouse is eligible for coverage if:

6 ~~(A)~~[\(i\)](#) The individual is a participant under the health benefit plan or has met any waiting
7 period applicable to becoming a participant under the plan and is eligible to be enrolled under the
8 plan, but for a failure to enroll during a previous enrollment period; and

9 ~~(B)~~[\(ii\)](#) A person becomes a dependent of the individual through marriage, birth, or
10 adoption or placement for adoption.

11 ~~(i)~~[\(2\)](#) The special enrollment period for individuals that meet the provisions of ~~paragraph~~
12 ~~(i) of this subdivision~~ [subsection \(d\)\(1\) of this section](#) is a period of not less than thirty (30) days
13 and begins on the later of:

14 ~~(A)~~[\(i\)](#) The date dependent coverage is made available; or

15 ~~(B)~~[\(ii\)](#) The date of the marriage, birth, or adoption or placement for adoption described in
16 ~~subparagraph (i)(B) of this subdivision~~ [subsection \(d\)\(1\)\(ii\) of this section](#).

17 ~~(iii)~~[\(3\)](#) If an individual seeks to enroll a dependent during the first thirty (30) days of the
18 dependent special enrollment period described under ~~paragraph (ii) of this subdivision~~ [subsection](#)
19 [\(d\)\(2\) of this section](#), the coverage of the dependent is effective:

20 ~~(A)~~[\(i\)](#) In the case of marriage, not later than the first day of the first month beginning
21 after the date the completed request for enrollment is received;

22 ~~(B)~~[\(ii\)](#) In the case of a dependent's birth, as of the date of birth; and

23 ~~(C)~~[\(iii\)](#) In the case of a dependent's adoption or placement for adoption, the date of the
24 adoption or placement for adoption.

25 ~~(9)(i)(e)~~[\(1\)](#) Except as provided in this subdivision, requirements used by a small
26 employer carrier in determining whether to provide coverage to a small employer, including
27 requirements for minimum participation of eligible employees and minimum employer
28 contributions, shall be applied uniformly among all small employers applying for coverage or
29 receiving coverage from the small employer carrier.

30 ~~(ii)~~[\(2\)](#) For health benefit plans issued or renewed on or after October 1, 2000, a small
31 employer carrier shall not require a minimum participation level greater than seventy-five percent
32 (75%) of eligible employees.

33 ~~(iii)~~[\(3\)](#) In applying minimum participation requirements with respect to a small employer,
34 a small employer carrier shall not consider employees or dependents who have creditable

1 coverage in determining whether the applicable percentage of participation is met.

2 ~~(iv)~~(4) A small employer carrier shall not increase any requirement for minimum
3 employee participation or modify any requirement for minimum employer contribution applicable
4 to a small employer at any time after the small employer has been accepted for coverage.

5 ~~(10)(i)(f)(1)~~ If a small employer carrier offers coverage to a small employer, the small
6 employer carrier shall offer coverage to all of the eligible employees of a small employer and
7 their dependents who apply for enrollment during the period in which the employee first becomes
8 eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to
9 only certain individuals or dependents in a small employer group or to only part of the group.

10 ~~(ii)~~(2) A small employer carrier shall not place any restriction in regard to any health
11 status-related factor on an eligible employee or dependent with respect to enrollment or plan
12 participation.

13 ~~(iii)~~(3) Except as permitted ~~under subdivisions (1) and (4) of this subsection~~ by this
14 section, a small employer carrier shall not modify a health benefit plan with respect to a small
15 employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to
16 restrict or exclude coverage or benefits for specific diseases, medical conditions, or services
17 covered by the plan.

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

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

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

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

30 (2) A small employer carrier that cannot offer coverage pursuant to ~~paragraph (1)(iii) of~~
31 ~~this subsection~~ subsection (g)(1)(iii) of this section may not offer coverage in the applicable area
32 to new cases of employer groups until the later of one hundred and eighty (180) days following
33 each refusal or the date on which the carrier notifies the ~~director~~ commissioner that it has
34 regained capacity to deliver services to new employer groups.

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

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

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

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

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

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

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

18 ~~(g)(i)~~(1) A small employer carrier is not required to provide coverage to small employers
19 pursuant to subsection ~~(b)(a)~~ of this section if the small employer carrier, in accordance with a
20 plan approved by the commissioner, elects not to offer new coverage to small employers in this
21 state.

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

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

30 ~~(h) No small group carrier may impose a pre-existing condition exclusion pursuant to the~~
31 ~~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-~~
32 ~~7(d)(5) and 27-50-7(d)(6) with regard to an individual that is less than nineteen (19) years of age.~~
33 ~~With respect to health benefit plans issued on and after January 1, 2014 a small employer carrier~~
34 ~~shall offer and issue coverage to small employers and eligible individuals notwithstanding any~~

1 ~~pre-existing condition of an employee, member, or individual, or their dependents.~~

2 (j) A small employer carrier shall not deny, exclude or limit benefits or coverage with
3 respect to an enrollee because of a preexisting condition exclusion.

4 **27-50-11. Administrative procedures.**

5 The ~~director~~ commissioner shall issue regulations in accordance with chapter 35 of ~~this~~
6 title 42 for the implementation and administration of the Small Employer Health Insurance
7 Availability Act. If provisions of the federal Patient Protection and Affordable Care Act and
8 implementing regulations, corresponding to the provisions of this chapter, are no longer in effect,
9 then the commissioner may promulgate regulations reflecting relevant federal law and
10 implementing regulations in effect immediately prior to such authorities no longer being in effect.
11 In the event of such changes to the law and related regulations, the commissioner, in conjunction
12 with the health benefit exchange or other state department, shall report to the general assembly as
13 soon as possible to describe the impact of the change and to make recommendations regarding
14 consumer protections, consumer choices, and stabilization and affordability of the Rhode Island
15 insurance market.

16 **27-50-12. Standards to assure fair marketing.**

17 (a) ~~Each~~ Unless permitted by the commissioner for a limited period of time, each small
18 employer carrier shall ~~actively market and~~ offer all health benefit plans sold by the carrier to
19 eligible small employers in the state.

20 (b)(1) Except as provided in subdivision (2) of this subsection, no small employer carrier
21 or producer shall, directly or indirectly, engage in the following activities:

22 (i) Encouraging or directing small employers to refrain from filing an application for
23 coverage with the small employer carrier because of any health status-related factor, age, gender,
24 industry, occupation, or geographic location of the small employer; or

25 (ii) Encouraging or directing small employers to seek coverage from another carrier
26 because of any health status-related factor, age, gender, industry, occupation, or geographic
27 location of the small employer.

28 (2) The provisions of subdivision (1) of this subsection do not apply with respect to
29 information provided by a small employer carrier or producer to a small employer regarding the
30 established geographic service area or a restricted network provision of a small employer carrier.

31 (c)(1) Except as provided in subdivision (2) of this subsection, no small employer carrier
32 shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer
33 that provides for or results in the compensation paid to a producer for the sale of a health benefit
34 plan to be varied because of any initial or renewal, industry, occupation, or geographic location of

1 the small employer.

2 (2) Subdivision (1) of this subsection does not apply with respect to a compensation
3 arrangement that provides compensation to a producer on the basis of percentage of premium,
4 provided that the percentage shall not vary because of any health status-related factor, industry,
5 occupation, or geographic area of the small employer.

6 ~~(d) A small employer carrier shall provide reasonable compensation, as provided under
7 the plan of operation of the program, to a producer, if any, for the sale of any health benefit plan
8 subject to § 27-50-10.~~

9 ~~(e)~~(d) No small employer carrier may terminate, fail to renew, or limit its contract or
10 agreement of representation with a producer for any reason related to health status-related factor,
11 occupation, or geographic location of the small employers placed by the producer with the small
12 employer carrier.

13 ~~(f)~~(e) No small employer carrier or producer shall induce or encourage a small employer
14 to separate or exclude an employee or dependent from health coverage or benefits provided in
15 connection with the employee's employment.

16 ~~(g)~~(f) Denial by a small employer carrier of an application for coverage from a small
17 employer shall be in writing and shall state the reason or reasons for the denial.

18 ~~(h)~~(g) The ~~director~~ commissioner may establish regulations setting forth additional
19 standards to provide for the fair marketing and broad availability of health benefit plans to small
20 employers in this state.

21 ~~(i)~~(h)(1) A violation of this section by a small employer carrier or a producer is an unfair
22 trade practice under chapter 13 of title 6.

23 (2) If a small employer carrier enters into a contract, agreement, or other arrangement
24 with a third-party administrator to provide administrative, marketing, or other services related to
25 the offering of health benefit plans to small employers in this state, the third-party administrator is
26 subject to this section as if it were a small employer carrier.

27 **27-50-15. Restoration of terminated coverage.**

28 The ~~director~~ commissioner may promulgate regulations to require small employer
29 carriers, as a condition of transacting business with small employers in this state after July 13,
30 2000, to reissue a health benefit plan to any small employer whose health benefit plan has been
31 terminated or not renewed by the carrier on or after July 1, 2000. The ~~director~~ commissioner may
32 prescribe any terms for the reissue of coverage that the ~~director~~ commissioner finds are
33 reasonable and necessary to provide continuity of coverage to small employers.

34 SECTION 9. Section 27-69-2 of the General Laws in Chapter 27-69 entitled "Mandated

1 Benefits" is hereby amended to read as follows:

2 **27-69-2. Definitions.**

3 (a) "Commissioner" shall mean the director of the department of business regulation or
4 the health insurance commissioner, as appropriate.

5 (b) "Health plan" shall mean "health insurance coverage" as defined in ~~subsections 27-~~
6 ~~18.5-2(8)(i)~~ [§§ 27-18.5-2\(12\)\(i\)](#) and ~~27-18.6-2(16)(i)~~ [27-18.6-2\(15\)](#) or "health benefit plan" as
7 defined in § 27-50-3.

8 (c) "High deductible health plan" shall have the same meaning as defined in 26 U.S.C.
9 223.

10 (d) "Mandated benefit law" shall mean any law of this state that requires provision of
11 health insurance coverage for a specified service or payment to a specified type of health care
12 provider, including, but not limited to, the benefits or services mandated in §§ 27-18-48.1, 27-18-
13 60, 27-18-62, 27-18-64, similar provisions in title 27, chapters 19, 20 and 41, and §§ 27-18-3(c),
14 27-38.2-1 et seq., and all mandated benefit laws passed subsequent to the effective date of this
15 chapter unless applicability of this chapter is specifically excluded in such law.

16 SECTION 10. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The
17 Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended
18 to read as follows:

19 **42-14.5-3. Powers and duties.**

20 The health insurance commissioner shall have the following powers and duties:

21 (a) To conduct quarterly public meetings throughout the state, separate and distinct from
22 rate hearings pursuant to § 42-62-13, regarding the rates, services, and operations of insurers
23 licensed to provide health insurance in the state; the effects of such rates, services, and operations
24 on consumers, medical care providers, patients, and the market environment in which the insurers
25 operate; and efforts to bring new health insurers into the Rhode Island market. Notice of not less
26 than ten (10) days of the hearing(s) shall go to the general assembly, the governor, the Rhode
27 Island Medical Society, the Hospital Association of Rhode Island, the director of health, the
28 attorney general, and the chambers of commerce. Public notice shall be posted on the
29 department's website and given in the newspaper of general circulation, and to any entity in
30 writing requesting notice.

31 (b) To make recommendations to the governor and the house of representatives and
32 senate finance committees regarding health-care insurance and the regulations, rates, services,
33 administrative expenses, reserve requirements, and operations of insurers providing health
34 insurance in the state, and to prepare or comment on, upon the request of the governor or

1 chairpersons of the house or senate finance committees, draft legislation to improve the regulation
2 of health insurance. In making the recommendations, the commissioner shall recognize that it is
3 the intent of the legislature that the maximum disclosure be provided regarding the
4 reasonableness of individual administrative expenditures as well as total administrative costs. The
5 commissioner shall make recommendations on the levels of reserves, including consideration of:
6 targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans for
7 distributing excess reserves.

8 (c) To establish a consumer/business/labor/medical advisory council to obtain
9 information and present concerns of consumers, business, and medical providers affected by
10 health-insurance decisions. The council shall develop proposals to allow the market for small
11 business health insurance to be affordable and fairer. The council shall be involved in the
12 planning and conduct of the quarterly public meetings in accordance with subsection (a). The
13 advisory council shall develop measures to inform small businesses of an insurance complaint
14 process to ensure that small businesses that experience rate increases in a given year may request
15 and receive a formal review by the department. The advisory council shall assess views of the
16 health-provider community relative to insurance rates of reimbursement, billing, and
17 reimbursement procedures, and the insurers' role in promoting efficient and high-quality health
18 care. The advisory council shall issue an annual report of findings and recommendations to the
19 governor and the general assembly and present its findings at hearings before the house and
20 senate finance committees. The advisory council is to be diverse in interests and shall include
21 representatives of community consumer organizations; small businesses, other than those
22 involved in the sale of insurance products; and hospital, medical, and other health-provider
23 organizations. Such representatives shall be nominated by their respective organizations. The
24 advisory council shall be co-chaired by the health insurance commissioner and a community
25 consumer organization or small business member to be elected by the full advisory council.

26 (d) To establish and provide guidance and assistance to a subcommittee ("the
27 professional-provider-health-plan work group") of the advisory council created pursuant to
28 subsection (c), composed of health-care providers and Rhode Island licensed health plans. This
29 subcommittee shall include in its annual report and presentation before the house and senate
30 finance committees the following information:

31 (1) A method whereby health plans shall disclose to contracted providers the fee
32 schedules used to provide payment to those providers for services rendered to covered patients;

33 (2) A standardized provider application and credentials-verification process, for the
34 purpose of verifying professional qualifications of participating health-care providers;

- 1 (3) The uniform health plan claim form utilized by participating providers;
- 2 (4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit
3 hospital or medical-service corporations, as defined by chapters 19 and 20 of title 27, to make
4 facility-specific data and other medical service-specific data available in reasonably consistent
5 formats to patients regarding quality and costs. This information would help consumers make
6 informed choices regarding the facilities and clinicians or physician practices at which to seek
7 care. Among the items considered would be the unique health services and other public goods
8 provided by facilities and clinicians or physician practices in establishing the most appropriate
9 cost comparisons;
- 10 (5) All activities related to contractual disclosure to participating providers of the
11 mechanisms for resolving health plan/provider disputes;
- 12 (6) The uniform process being utilized for confirming, in real time, patient insurance
13 enrollment status, benefits coverage, including co-pays and deductibles;
- 14 (7) Information related to temporary credentialing of providers seeking to participate in
15 the plan's network and the impact of the activity on health-plan accreditation;
- 16 (8) The feasibility of regular contract renegotiations between plans and the providers in
17 their networks; and
- 18 (9) Efforts conducted related to reviewing impact of silent PPOs on physician practices.
- 19 (e) To enforce the provisions of Title 27 and Title 42 as set forth in § 42-14-5(d).
- 20 (f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The
21 fund shall be used to effectuate the provisions of ~~§§ 27-18.5-9 and~~ 27-50-17.
- 22 (g) To analyze the impact of changing the rating guidelines and/or merging the individual
23 health-insurance market, as defined in chapter 18.5 of title 27, and the small-employer-health-
24 insurance market, as defined in chapter 50 of title 27, in accordance with the following:
- 25 (1) The analysis shall forecast the likely rate increases required to effect the changes
26 recommended pursuant to the preceding subsection (g) in the direct-pay market and small-
27 employer-health-insurance market over the next five (5) years, based on the current rating
28 structure and current products.
- 29 (2) The analysis shall include examining the impact of merging the individual and small-
30 employer markets on premiums charged to individuals and small-employer groups.
- 31 (3) The analysis shall include examining the impact on rates in each of the individual and
32 small-employer health-insurance markets and the number of insureds in the context of possible
33 changes to the rating guidelines used for small-employer groups, including: community rating
34 principles; expanding small-employer rate bonds beyond the current range; increasing the

1 employer group size in the small-group market; and/or adding rating factors for broker and/or
2 tobacco use.

3 (4) The analysis shall include examining the adequacy of current statutory and regulatory
4 oversight of the rating process and factors employed by the participants in the proposed, new
5 merged market.

6 (5) The analysis shall include assessment of possible reinsurance mechanisms and/or
7 federal high-risk pool structures and funding to support the health-insurance market in Rhode
8 Island by reducing the risk of adverse selection and the incremental insurance premiums charged
9 for this risk, and/or by making health insurance affordable for a selected at-risk population.

10 (6) The health insurance commissioner shall work with an insurance market merger task
11 force to assist with the analysis. The task force shall be chaired by the health insurance
12 commissioner and shall include, but not be limited to, representatives of the general assembly, the
13 business community, small-employer carriers as defined in § 27-50-3, carriers offering coverage
14 in the individual market in Rhode Island, health-insurance brokers, and members of the general
15 public.

16 (7) For the purposes of conducting this analysis, the commissioner may contract with an
17 outside organization with expertise in fiscal analysis of the private-insurance market. In
18 conducting its study, the organization shall, to the extent possible, obtain and use actual health-
19 plan data. Said data shall be subject to state and federal laws and regulations governing
20 confidentiality of health care and proprietary information.

21 (8) The task force shall meet as necessary and include its findings in the annual report,
22 and the commissioner shall include the information in the annual presentation before the house
23 and senate finance committees.

24 (h) To establish and convene a workgroup representing health-care providers and health
25 insurers for the purpose of coordinating the development of processes, guidelines, and standards
26 to streamline health-care administration that are to be adopted by payors and providers of health-
27 care services operating in the state. This workgroup shall include representatives with expertise
28 who would contribute to the streamlining of health-care administration and who are selected from
29 hospitals, physician practices, community behavioral-health organizations, each health insurer,
30 and other affected entities. The workgroup shall also include at least one designee each from the
31 Rhode Island Medical Society, Rhode Island Council of Community Mental Health
32 Organizations, the Rhode Island Health Center Association, and the Hospital Association of
33 Rhode Island. The workgroup shall consider and make recommendations for:

34 (1) Establishing a consistent standard for electronic eligibility and coverage verification.

1 Such standard shall:

2 (i) Include standards for eligibility inquiry and response and, wherever possible, be
3 consistent with the standards adopted by nationally recognized organizations, such as the Centers
4 for Medicare and Medicaid Services;

5 (ii) Enable providers and payors to exchange eligibility requests and responses on a
6 system-to-system basis or using a payor-supported web browser;

7 (iii) Provide reasonably detailed information on a consumer's eligibility for health-care
8 coverage; scope of benefits; limitations and exclusions provided under that coverage; cost-sharing
9 requirements for specific services at the specific time of the inquiry; current deductible amounts;
10 accumulated or limited benefits; out-of-pocket maximums; any maximum policy amounts; and
11 other information required for the provider to collect the patient's portion of the bill;

12 (iv) Reflect the necessary limitations imposed on payors by the originator of the
13 eligibility and benefits information;

14 (v) Recommend a standard or common process to protect all providers from the costs of
15 services to patients who are ineligible for insurance coverage in circumstances where a payor
16 provides eligibility verification based on best information available to the payor at the date of the
17 request of eligibility.

18 (2) Developing implementation guidelines and promoting adoption of the guidelines for:

19 (i) The use of the National Correct Coding Initiative code-edit policy by payors and
20 providers in the state;

21 (ii) Publishing any variations from codes and mutually exclusive codes by payors in a
22 manner that makes for simple retrieval and implementation by providers;

23 (iii) Use of Health Insurance Portability and Accountability Act standard group codes,
24 reason codes, and remark codes by payors in electronic remittances sent to providers;

25 (iv) The processing of corrections to claims by providers and payors.

26 (v) A standard payor-denial review process for providers when they request a
27 reconsideration of a denial of a claim that results from differences in clinical edits where no
28 single, common-standards body or process exists and multiple conflicting sources are in use by
29 payors and providers.

30 (vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual
31 payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of
32 detecting and deterring fraudulent billing activities. The guidelines shall require that each payor
33 disclose to the provider its adjudication decision on a claim that was denied or adjusted based on
34 the application of such edits and that the provider have access to the payor's review and appeal

1 process to challenge the payor's adjudication decision.

2 (vii) Nothing in this subsection shall be construed to modify the rights or obligations of
3 payors or providers with respect to procedures relating to the investigation, reporting, appeal, or
4 prosecution under applicable law of potentially fraudulent billing activities.

5 (3) Developing and promoting widespread adoption by payors and providers of
6 guidelines to:

7 (i) Ensure payors do not automatically deny claims for services when extenuating
8 circumstances make it impossible for the provider to obtain a preauthorization before services are
9 performed or notify a payor within an appropriate standardized timeline of a patient's admission;

10 (ii) Require payors to use common and consistent processes and time frames when
11 responding to provider requests for medical management approvals. Whenever possible, such
12 time frames shall be consistent with those established by leading national organizations and be
13 based upon the acuity of the patient's need for care or treatment. For the purposes of this section,
14 medical management includes prior authorization of services, preauthorization of services,
15 precertification of services, post-service review, medical-necessity review, and benefits advisory;

16 (iii) Develop, maintain, and promote widespread adoption of a single, common website
17 where providers can obtain payors' preauthorization, benefits advisory, and preadmission
18 requirements;

19 (iv) Establish guidelines for payors to develop and maintain a website that providers can
20 use to request a preauthorization, including a prospective clinical necessity review; receive an
21 authorization number; and transmit an admission notification.

22 (4) To provide a report to the house and senate, on or before January 1, 2017, with
23 recommendations for establishing guidelines and regulations for systems that give patients
24 electronic access to their claims information, particularly to information regarding their
25 obligations to pay for received medical services, pursuant to 45 C.F.R. 164.524.

26 (i) To issue an anti-cancer medication report. Not later than June 30, 2014 and annually
27 thereafter, the office of the health insurance commissioner (OHIC) shall provide the senate
28 committee on health and human services, and the house committee on corporations, with: (1)
29 Information on the availability in the commercial market of coverage for anti-cancer medication
30 options; (2) For the state employee's health benefit plan, the costs of various cancer-treatment
31 options; (3) The changes in drug prices over the prior thirty-six (36) months; and (4) Member
32 utilization and cost-sharing expense.

33 (j) To monitor the adequacy of each health plan's compliance with the provisions of the
34 federal Mental Health Parity Act, including a review of related claims processing and

1 reimbursement procedures. Findings, recommendations, and assessments shall be made available
2 to the public.

3 (k) To monitor the transition from fee-for-service and toward global and other alternative
4 payment methodologies for the payment for health-care services. Alternative payment
5 methodologies should be assessed for their likelihood to promote access to affordable health
6 insurance, health outcomes, and performance.

7 (l) To report annually, no later than July 1, 2014, then biannually thereafter, on hospital
8 payment variation, including findings and recommendations, subject to available resources.

9 (m) Notwithstanding any provision of the general or public laws or regulation to the
10 contrary, provide a report with findings and recommendations to the president of the senate and
11 the speaker of the house, on or before April 1, 2014, including, but not limited to, the following
12 information:

13 (1) The impact of the current, mandated health-care benefits as defined in §§ 27-18-48.1,
14 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41, of title 27, and §§ 27-
15 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health
16 insurance for fully insured employers, subject to available resources;

17 (2) Current provider and insurer mandates that are unnecessary and/or duplicative due to
18 the existing standards of care and/or delivery of services in the health-care system;

19 (3) A state-by-state comparison of health-insurance mandates and the extent to which
20 Rhode Island mandates exceed other states benefits; and

21 (4) Recommendations for amendments to existing mandated benefits based on the
22 findings in (m)(1), (m)(2), and (m)(3) above.

23 (n) On or before July 1, 2014, the office of the health insurance commissioner, in
24 collaboration with the director of health and lieutenant governor's office, shall submit a report to
25 the general assembly and the governor to inform the design of accountable care organizations
26 (ACOs) in Rhode Island as unique structures for comprehensive health-care delivery and value-
27 based payment arrangements, that shall include, but not be limited to:

28 (1) Utilization review;

29 (2) Contracting; and

30 (3) Licensing and regulation.

31 (o) On or before February 3, 2015, the office of the health insurance commissioner shall
32 submit a report to the general assembly and the governor that describes, analyzes, and proposes
33 recommendations to improve compliance of insurers with the provisions of § 27-18-76 with
34 regard to patients with mental-health and substance-use disorders.

1 (p) To work to ensure the health insurance coverage of behavioral health care under the
2 same terms and conditions as other health care, and to integrate behavioral health parity
3 requirements into the office of the health insurance commissioner insurance oversight and health
4 care transformation efforts.

5 (q) To work with other state agencies to seek delivery system improvements that enhance
6 access to a continuum of mental-health and substance-use disorder treatment in the state; and
7 integrate that treatment with primary and other medical care to the fullest extent possible.

8 (r) To direct insurers toward policies and practices that address the behavioral health
9 needs of the public and greater integration of physical and behavioral health care delivery.

10 (s) The office of the health insurance commissioner shall conduct an analysis of the
11 impact of the provisions of § 27-38.2-1(i) on health insurance premiums and access in Rhode
12 Island and submit a report of its findings to the general assembly on or before June 1, 2023.

13 SECTION 11. Chapter 27-18.5 of the General Laws entitled "Individual Health Insurance
14 Coverage" is hereby amended by adding thereto the following section:

15 **27-18.5-11. Cost sharing requirements.**

16 (a) Annual limitation on cost sharing.

17 (1) For a health benefit plan year beginning in a calendar year after 2020, cost sharing in
18 a health benefit plan may not exceed the following:

19 (i) For self-only coverage - the dollar limit for calendar year 2019 defined by the Internal
20 Revenue Service as in place as of January 1, 2019, increased by an amount equal to the product of
21 that amount and the premium adjustment percentage, as defined in subsection (d) of this section.

22 (ii) For other than self-only coverage - twice the dollar limit for self-only coverage
23 described in subsection (a)(1)(i) of this section.

24 (b) Increase annual dollar limits in multiples of fifty (50). For a health benefit plan year
25 beginning in a calendar year after 2020, any increase in the annual dollar limits described in
26 subsection (a) of this section that does not result in a multiple of fifty dollars (\$50.00) shall be
27 rounded down, to the next lowest multiple of fifty dollars (\$50.00).

28 (c) Premium adjustment percentage. The premium adjustment percentage is the
29 percentage (if any) by which the average per capita premium for commercial health insurance
30 coverage in Rhode Island for the preceding calendar year exceeds the average per capita premium
31 for commercial health insurance for 2019. The office of the health insurance commissioner shall
32 publicly publish the annual premium adjustment percentage.

33 (d) Coordination with preventive limits. Nothing in this section is in derogation of the
34 requirements of preventive services coverage as defined in §§ 27-18.5-2 and 27-50-3.

1 (e) Coverage of emergency department services. Emergency department services must be
2 provided as follows:

3 (1) Without imposing any requirement under the health benefit plan for prior
4 authorization of services or any limitation on coverage where the provider of services is out-of-
5 network that is more restrictive than the requirements or limitations that apply to emergency
6 department services received in network; and

7 (2) If the services are provided out-of-network, cost sharing must be limited as provided
8 in federal regulation 45 CFR §147.138(b)(3) so long as they remain in effect, and if struck then
9 those in effect as of the date immediately prior shall control.

10 (f) Authority. The health insurance commissioner shall have the authority to promulgate
11 regulations consistent with this chapter.

12 SECTION 12. Chapter 27-18.6 of the General Laws entitled "Large Group Health
13 Insurance Coverage" is hereby amended by adding thereto the following section:

14 **27-18.6-13. Compliance with federal law.**

15 A carrier shall comply with all federal laws and regulations relating to health insurance
16 coverage in the large group market. In its construction and enforcement of the provisions of this
17 section, and in the interests of promoting uniform national rules for health insurance carriers
18 while protecting the interests of Rhode Island consumers and businesses, the office of the health
19 insurance commissioner shall give due deference to the construction, enforcement policies, and
20 guidance of the federal government with respect to federal laws substantially similar to the
21 provisions of this chapter.

22 SECTION 13. Chapter 27-50 of the General Laws entitled "Small Employer Health
23 Insurance Availability Act" is hereby amended by adding thereto the following section:

24 **27-50-18. Cost sharing requirements.**

25 (a) Annual limitation on cost sharing.

26 (1) For a health benefit plan year beginning in a calendar year after 2020, cost sharing in
27 a health benefit plan may not exceed the following:

28 (i) For self-only coverage - the dollar limit for calendar year 2019 defined by the Internal
29 Revenue Service as in place as of January 1, 2019, increased by an amount equal to the product of
30 that amount and the premium adjustment percentage, as defined in subsection (d) of this section.

31 (ii) For other than self-only coverage - twice the dollar limit for self-only coverage
32 described in subsection (a)(1)(i) of this section.

33 (b) Increase annual dollar limits in multiples of fifty (50). For a health benefit plan year
34 beginning in a calendar year after 2020, any increase in the annual dollar limits described in

1 subsection (a) of this section that does not result in a multiple of fifty dollars (\$50.00) shall be
2 rounded down, to the next lowest multiple of fifty dollars (\$50.00).

3 (c) Premium adjustment percentage. The premium adjustment percentage is the
4 percentage (if any) by which the average per capita premium for commercial health insurance
5 coverage in Rhode Island for the preceding calendar year exceeds the average per capita premium
6 for commercial health insurance for 2019. The office of the health insurance commissioner shall
7 publicly publish the annual premium adjustment percentage.

8 (d) Coordination with preventive limits. Nothing in this section is in derogation of the
9 requirements of preventive services coverage as defined in §§ 27-18.5-2 and 27-50-3.

10 (e) Coverage of emergency department services. Emergency department services must be
11 provided as follows:

12 (1) Without imposing any requirement under the health benefit plan for prior
13 authorization of services or any limitation on coverage where the provider of services is out-of-
14 network that is more restrictive than the requirements or limitations that apply to emergency
15 department services received in network; and

16 (2) If the services are provided out-of-network, cost sharing must be limited as provided
17 in federal regulation 45 CFR §147.138(b)(3) so long as they remain in effect, and if struck then
18 those in effect as of the date immediately prior shall control.

19 (f) Authority. The health insurance commissioner shall have the authority to promulgate
20 regulations consistent with this chapter.

21 SECTION 14. Sections 27-18.5-8 and 27-18.5-9 of the General Laws in Chapter 27-18.5
22 entitled "Individual Health Insurance Coverage" are hereby repealed.

23 ~~**27-18.5-8. Wellness health benefit plan.**~~

24 ~~All carriers that offer health insurance in the individual market shall actively market and~~
25 ~~offer the wellness health direct benefit plan to eligible individuals. The wellness health direct~~
26 ~~benefit plan shall be determined by regulation promulgated by the office of the health insurance~~
27 ~~commissioner (OHIC). The OHIC shall develop the criteria for the direct wellness health benefit~~
28 ~~plan, including, but not limited to, benefit levels, cost sharing levels, exclusions and limitations in~~
29 ~~accordance with the following:~~

30 ~~(1) Form and utilize an advisory committee in accordance with subsection 27-50-10(5).~~

31 ~~(2) Set a target for the average annualized individual premium rate for the direct wellness~~
32 ~~health benefit plan to be less than ten percent (10%) of the average annual statewide wage,~~
33 ~~dependent upon the availability of reinsurance funds, as reported by the Rhode Island department~~
34 ~~of labor and training, in their report entitled "Quarterly Census of Rhode Island Employment and~~

1 ~~Wages." In the event that this report is no longer available, or the OHIC determines that it is no~~
2 ~~longer appropriate for the determination of maximum annualized premium, an alternative method~~
3 ~~shall be adopted in regulation by the OHIC. The maximum annualized individual premium rate~~
4 ~~shall be determined no later than August 1st of each year, to be applied to the subsequent calendar~~
5 ~~year premiums rates.~~

6 ~~(3) Ensure that the direct wellness health benefit plan creates appropriate incentives for~~
7 ~~employers, providers, health plans and consumers to, among other things:~~

8 ~~(i) Focus on primary care, prevention and wellness;~~

9 ~~(ii) Actively manage the chronically ill population;~~

10 ~~(iii) Use the least cost, most appropriate setting; and~~

11 ~~(iv) Use evidence based, quality care.~~

12 ~~(4) The plan shall be made available in accordance with title 27, chapter 18.5 as required~~
13 ~~by regulation on or before May 1, 2007.~~

14 ~~**27-18.5-9. Affordable health plan reinsurance program for individuals.**~~

15 ~~(a) The commissioner shall allocate funds from the affordable health plan reinsurance~~
16 ~~fund for the affordable health reinsurance program.~~

17 ~~(b) The affordable health reinsurance program for individuals shall only be available to~~
18 ~~high risk individuals as defined in § 27-18.5-2, and who purchase the direct wellness health~~
19 ~~benefit plan pursuant to the provisions of this section. Eligibility shall be determined based on~~
20 ~~state and federal income tax filings.~~

21 ~~(c) The affordable health plan reinsurance shall be in the form of a carrier cost sharing~~
22 ~~arrangement, which encourages carriers to offer a discounted premium rate to participating~~
23 ~~individuals, and whereby the reinsurance fund subsidizes the carriers' losses within a prescribed~~
24 ~~corridor of risk as determined by regulation.~~

25 ~~(d) The specific structure of the reinsurance arrangement shall be defined by regulations~~
26 ~~promulgated by the commissioner.~~

27 ~~(e) The commissioner shall determine total eligible enrollment under qualifying~~
28 ~~individual health insurance contracts by dividing the funds available for distribution from the~~
29 ~~reinsurance fund by the estimated per member annual cost of claims reimbursement from the~~
30 ~~reinsurance fund.~~

31 ~~(f) The commissioner shall suspend the enrollment of new individuals under qualifying~~
32 ~~individual health insurance contracts if the director determines that the total enrollment reported~~
33 ~~under such contracts is projected to exceed the total eligible enrollment, thereby resulting in~~
34 ~~anticipated annual expenditures from the reinsurance fund in excess of ninety five percent (95%)~~

1 ~~of the total funds available for distribution from the fund.~~

2 ~~(g) The commissioner shall provide the health maintenance organization, health insurers~~
3 ~~and health plans with notification of any enrollment suspensions as soon as practicable after~~
4 ~~receipt of all enrollment data.~~

5 ~~(h) The premiums of qualifying individual health insurance contracts must be no more~~
6 ~~than ninety percent (90%) of the actuarially determined and commissioner approved premium for~~
7 ~~this health plan without the reinsurance program assistance.~~

8 ~~(i) The commissioner shall prepare periodic public reports in order to facilitate evaluation~~
9 ~~and ensure orderly operation of the funds, including, but not limited to, an annual report of the~~
10 ~~affairs and operations of the fund, containing an accounting of the administrative expenses~~
11 ~~charged to the fund. Such reports shall be delivered to the co chairs of the joint legislative~~
12 ~~committee on health care oversight by March 1st of each year.~~

13 SECTION 15. Sections 27-50-9, 27-50-10, 27-50-16 and 27-50-17 of the General Laws
14 in Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" are hereby
15 repealed.

16 ~~**27-50-9. Periodic market evaluation.**~~

17 ~~Within three (3) months after March 31, 2002, and every thirty six (36) months after this,~~
18 ~~the director shall obtain an independent actuarial study and report. The director shall assess a fee~~
19 ~~to the health plans to commission the report. The report shall analyze the effectiveness of the~~
20 ~~chapter in promoting rate stability, product availability, and coverage affordability. The report~~
21 ~~may contain recommendations for actions to improve the overall effectiveness, efficiency, and~~
22 ~~fairness of the small group health insurance marketplace. The report shall address whether~~
23 ~~carriers and producers are fairly actively marketing or issuing health benefit plans to small~~
24 ~~employers in fulfillment of the purposes of the chapter. The report may contain recommendations~~
25 ~~for market conduct or other regulatory standards or action.~~

26 ~~**27-50-10. Wellness health benefit plan.**~~

27 ~~(a) No provision contained in this chapter prohibits the sale of health benefit plans which~~
28 ~~differ from the wellness health benefit plans provided for in this section.~~

29 ~~(b) The wellness health benefit plan shall be determined by regulations promulgated by~~
30 ~~the office of health insurance commissioner (OHIC). The OHIC shall develop the criteria for the~~
31 ~~wellness health benefit plan, including, but not limited to, benefit levels, cost sharing levels,~~
32 ~~exclusions, and limitations, in accordance with the following:~~

33 ~~(1)(i) The OHIC shall form an advisory committee to include representatives of~~
34 ~~employers, health insurance brokers, local chambers of commerce, and consumers who pay~~

1 ~~directly for individual health insurance coverage.~~

2 ~~(ii) The advisory committee shall make recommendations to the OHIC concerning the~~
3 ~~following:~~

4 ~~(A) The wellness health benefit plan requirements document. This document shall be~~
5 ~~disseminated to all Rhode Island small group and individual market health plans for responses,~~
6 ~~and shall include, at a minimum, the benefit limitations and maximum cost sharing levels for the~~
7 ~~wellness health benefit plan. If the wellness health benefit product requirements document is not~~
8 ~~created by November 1, 2006, it will be determined by regulations promulgated by the OHIC.~~

9 ~~(B) The wellness health benefit plan design. The health plans shall bring proposed~~
10 ~~wellness health plan designs to the advisory committee for review on or before January 1, 2007.~~
11 ~~The advisory committee shall review these proposed designs and provide recommendations to the~~
12 ~~health plans and the commissioner regarding the final wellness plan design to be approved by the~~
13 ~~commissioner in accordance with subsection 27-50-5(h)(4), and as specified in regulations~~
14 ~~promulgated by the commissioner on or before March 1, 2007.~~

15 ~~(2) Set a target for the average annualized individual premium rate for the wellness health~~
16 ~~benefit plan to be less than ten percent (10%) of the average annual statewide wage, as reported~~
17 ~~by the Rhode Island department of labor and training, in their report entitled "Quarterly Census of~~
18 ~~Rhode Island Employment and Wages." In the event that this report is no longer available, or the~~
19 ~~OHIC determines that it is no longer appropriate for the determination of maximum annualized~~
20 ~~premium, an alternative method shall be adopted in regulation by the OHIC. The maximum~~
21 ~~annualized individual premium rate shall be determined no later than August 1st of each year, to~~
22 ~~be applied to the subsequent calendar year premium rates.~~

23 ~~(3) Ensure that the wellness health benefit plan creates appropriate incentives for~~
24 ~~employers, providers, health plans and consumers to, among other things:~~

- 25 ~~(i) Focus on primary care, prevention and wellness;~~
- 26 ~~(ii) Actively manage the chronically ill population;~~
- 27 ~~(iii) Use the least cost, most appropriate setting; and~~
- 28 ~~(iv) Use evidence based, quality care.~~

29 ~~(4) To the extent possible, the health plans may be permitted to utilize existing products~~
30 ~~to meet the objectives of this section.~~

31 ~~(5) The plan shall be made available in accordance with title 27, chapter 50 as required~~
32 ~~by regulation on or before May 1, 2007.~~

33 ~~**27-50-16. Risk adjustment mechanism.**~~

34 ~~The director may establish a payment mechanism to adjust for the amount of risk covered~~

1 ~~by each small employer carrier. The director may appoint an advisory committee composed of~~
2 ~~individuals that have risk adjustment and actuarial expertise to help establish the risk adjusters.~~

3 ~~**27-50-17. Affordable health plan reinsurance program for small businesses.**~~

4 ~~(a) The commissioner shall allocate funds from the affordable health plan reinsurance~~
5 ~~fund for the affordable health reinsurance program.~~

6 ~~(b) The affordable health reinsurance program for small businesses shall only be~~
7 ~~available to low wage firms, as defined in § 27-50-3, who pay a minimum of fifty percent (50%),~~
8 ~~as defined in § 27-50-3, of single coverage premiums for their eligible employees, and who~~
9 ~~purchase the wellness health benefit plan pursuant to § 27-50-10. Eligibility shall be determined~~
10 ~~based on state and federal corporate tax filings. All eligible employees, as defined in § 27-50-3,~~
11 ~~employed by low wage firms as defined in § 27-50-3 (oo) shall be eligible for the reinsurance~~
12 ~~program if at least one low wage eligible employee as defined in regulation is enrolled in the~~
13 ~~employer's wellness health benefit plan.~~

14 ~~(c) The affordable health plan reinsurance shall be in the firms of a carrier cost sharing~~
15 ~~arrangement, which encourages carriers to offer a discounted premium rate to participating~~
16 ~~individuals, and whereby the reinsurance fund subsidizes the carriers' losses within a prescribed~~
17 ~~corridor of risk as determined by regulation.~~

18 ~~(d) The specific structure of the reinsurance arrangement shall be defined by regulations~~
19 ~~promulgated by the commissioner.~~

20 ~~(e) All carriers who participate in the Rhode Island RItE Care program as defined in § 42-~~
21 ~~12.3-4 and the procurement process for the Rhode Island state employee account, as described in~~
22 ~~chapter 36-12, must participate in the affordable health plan reinsurance program.~~

23 ~~(f) The commissioner shall determine total eligible enrollment under qualifying small~~
24 ~~group health insurance contracts by dividing the funds available for distribution from the~~
25 ~~reinsurance fund by the estimated per member annual cost of claims reimbursement from the~~
26 ~~reinsurance fund.~~

27 ~~(g) The commissioner shall suspend the enrollment of new employers under qualifying~~
28 ~~small group health insurance contracts if the director determines that the total enrollment reported~~
29 ~~under such contracts is projected to exceed the total eligible enrollment, thereby resulting in~~
30 ~~anticipated annual expenditures from the reinsurance fund in excess of ninety five percent (95%)~~
31 ~~of the total funds available for distribution from the fund.~~

32 ~~(h) In the event the available funds in the affordable health reinsurance fund as created in~~
33 ~~§ 42-14.5-3 are insufficient to satisfy all claims submitted to the fund in any calendar year, those~~
34 ~~claims in excess of the available funds shall be due and payable in the succeeding calendar year,~~

1 ~~or when sufficient funds become available whichever shall first occur. Unpaid claims from any~~
2 ~~prior year shall take precedence over new claims submitted in any one year.~~

3 ~~(i) The commissioner shall provide the health maintenance organization, health insurers~~
4 ~~and health plans with notification of any enrollment suspensions as soon as practicable after~~
5 ~~receipt of all enrollment data. However, the suspension of issuance of qualifying small group~~
6 ~~health insurance contracts shall not preclude the addition of new employees of an employer~~
7 ~~already covered under such a contract or new dependents of employees already covered under~~
8 ~~such contracts.~~

9 ~~(j) The premiums of qualifying small group health insurance contracts must be no more~~
10 ~~than ninety percent (90%) of the actuarially determined and commissioner approved premium for~~
11 ~~this health plan without the reinsurance program assistance.~~

12 ~~(k) The commissioner shall prepare periodic public reports in order to facilitate~~
13 ~~evaluation and ensure orderly operation of the funds, including, but not limited to, an annual~~
14 ~~report of the affairs and operations of the fund, containing an accounting of the administrative~~
15 ~~expenses charged to the fund. Such reports shall be delivered to the co chairs of the joint~~
16 ~~legislative committee on health care oversight by March 1st of each year.~~

17 SECTION 16. This act shall take effect upon passage and shall apply to health benefit
18 plans issued or renewed on and after January 1, 2020.

=====
LC002242
=====

EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO INSURANCE -- HEALTH INSURANCE COVERAGE--MARKET
STABILITY AND CONSUMER PROTECTION ACT

1 This act would establish the Rhode Island health insurance market stability and consumer
2 protection act in order to update state law to reflect current insurance standards, practice and
3 regulation to maintain market stability, including using current rating factors, continuing the use
4 of a medical loss ratio standard, and providing coverage for benefits consistent with all applicable
5 federal and state laws and regulations. Consumer protections contained in the act would include
6 current requirements to: ban pre-existing condition exclusions; limit annual insurance coverage
7 caps; coverage of preventive services without patient cost sharing, coverage of essential health
8 benefits and provide summaries of benefits for consumers.

9 This act would take effect upon passage.

=====
LC002242
=====