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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2012

AN ACT

RELATING TO INSURANCE -- HEALTH INSURANCE - CONSUMER PROTECTION

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

Date Introduced: March 07, 2012

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Purpose and intent.

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

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

9 **27-18-1-1. Definitions. –** As used in this chapter:

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

1 (2) 'Affordable Care Act' means the Patient Protection and Affordable Care Act of 2010,
2 as amended by the Health Care and Education Reconciliation Act of 2010.
3 (3) "Commissioner" or "health insurance commissioner" means that individual appointed
4 pursuant to section 42-14.5-1 of the general laws.
5 (4) "Grandfathered health plan" means any group health plan or health insurance
6 coverage subject to 42 USC section 18011.
7 (5) "Group health insurance coverage" means, in connection with a group health plan,
8 health insurance coverage offered in connection with such plan.
9 (6) "Group health plan" means an employee welfare benefit plan, as defined in 29 USC
10 section 1002(1), to the extent that the plan provides health benefits to employees or their
11 dependents directly or through insurance, reimbursement, or otherwise.
12 (7) "Health benefits" or "covered benefits" means medical, surgical, hospital,
13 prescription drug, and such other benefits, whether self-funded, or delivered through the purchase
14 of insurance or otherwise.
15 (8) "Health care facility" means an institution providing health care services or a health
16 care setting, including, but not limited to, hospitals and other licensed inpatient centers,
17 ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers,
18 diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health
19 settings.
20 (9) "Health care professional" means a physician or other health care practitioner
21 licensed, accredited or certified to perform specified health care services consistent with state
22 law.
23 (10) "Health care provider" or "provider" means a health care professional or a health
24 care facility.
25 (11) "Health care services" means services for the diagnosis, prevention, treatment, cure
26 or relief of a health condition, illness, injury or disease.
27 (12) "Health insurance carrier" means a person, firm, corporation or other entity subject
28 to the jurisdiction of the commissioner under this chapter. Such term does not include a group
29 health plan.
30 (13) "Health plan" or "health benefit plan" means health insurance coverage and a group
31 health plan, including coverage provided through an association plan if it covers Rhode Island
32 residents. Except to the extent specifically provided by the Affordable Care Act, the term "health
33 plan" shall not include a group health plan to the extent state regulation of the health plan is pre-
34 empted under section 514 of the Employee Retirement Income Security Act of 1974. The term

1 also shall not include:
2 (A)(i) Coverage only for accident, or disability income insurance, or any combination
3 thereof.
4 (ii) Coverage issued as a supplement to liability insurance.
5 (iii) Liability insurance, including general liability insurance and automobile liability
6 insurance.
7 (iv) Workers' compensation or similar insurance.
8 (v) Automobile medical payment insurance.
9 (vi) Credit-only insurance.
10 (vii) Coverage for on-site medical clinics.
11 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant to
12 Pub. L. No. 104-191, the health insurance portability and accountability act of 1996 ("HIPAA"),
13 under which benefits for medical care are secondary or incidental to other insurance benefits.
14 (B) The following benefits if they are provided under a separate policy, certificate or
15 contract of insurance or are otherwise not an integral part of the plan:
16 (i) Limited scope dental or vision benefits.
17 (ii) Benefits for long-term care, nursing home care, home health care, community-based
18 care, or any combination thereof.
19 (iii) Other excepted benefits specified in federal regulations issued pursuant to Pub. L.
20 No. 104-191 ("HIPAA").
21 (C) The following benefits if the benefits are provided under a separate policy, certificate
22 or contract of insurance, there is no coordination between the provision of the benefits and any
23 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the
24 benefits are paid with respect to an event without regard to whether benefits are provided with
25 respect to such an event under any group health plan maintained by the same plan sponsor:
26 (i) Coverage only for a specified disease or illness.
27 (ii) Hospital indemnity or other fixed indemnity insurance.
28 (D) The following if offered as a separate policy, certificate or contract of insurance:
29 (i) Medicare supplement health insurance as defined under section 1882(g)(1) of the
30 Social Security Act.
31 (ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United
32 States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).
33 (iii) Similar supplemental coverage provided to coverage under a group health plan.
34 (14) "Office of the health insurance commissioner" means the agency established under

1 section 42-14.5-1 of the General laws.

2 (15) “Rescission" means a cancellation or discontinuance of coverage that has retroactive

3 effect for reasons unrelated to timely payment of required premiums or contribution to costs of

4 coverage.

5 **27-18-2.1. Uniform explanation of benefits and coverage. –** (a) A health insurance

6 carrier shall provide a uniform summary of benefits and coverage explanation and standardized

7 definitions to policyholders and others required by, and at the times required, by the federal

8 regulations adopted under section 2715 of the Affordable Care Act. A summary required by this

9 section shall be filed with the commissioner for approval under Rhode Island general laws section

10 27-18-8 et seq. The requirements of this section shall be in addition to the requirements of Rhode

11 Island general laws section 27-18-8 et seq. The commissioner may waive one or more of the

12 requirements of the regulations adopted under section 2715 of the Affordable Care Act for good

13 cause shown. The summary must contain at least the following information:

14 (1) Uniform definitions of standard insurance and medical terms.

15 (2) A description of coverage and cost sharing for each category of essential benefits and

16 other benefits.

17 (3) Exceptions, reductions and limitations in coverage.

18 (4) Renewability and continuation of coverage provisions.

19 (5) A “coverage facts label” that illustrates coverage under common benefits scenarios.

20 (6) A statement of whether the policy, contract or plan provides the minimum coverage

21 required of a qualified health plan.

22 (7) A statement that the outline is a summary and that the actual policy language should

23 be consulted; and

24 (8) A contact number for the consumer to call with additional questions and the web

25 address of where the actual language of the policy, contract or plan can be found.

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

27 **27-18-78. Prohibition on rescission of coverage. –** (a)(1) Coverage under a health

28 benefit plan subject to the jurisdiction of the commissioner under this chapter with respect to an

29 individual, including a group to which the individual belongs or family coverage in which the

30 individual is included, shall not be rescinded after the individual is covered under the plan,

31 unless:

32 (A) The individual or a person seeking coverage on behalf of the individual, performs an

33 act, practice or omission that constitutes fraud; or

34 (B) The individual makes an intentional misrepresentation of material fact, as prohibited

by the terms of the plan or coverage.

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

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

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

(d) This section applies to grandfathered health plans.

27-18-79. Prohibition on annual and lifetime limits. – (a) Annual limits.

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

(A) For a plan or policy year beginning after September 22, 2010, but before September 23, 2011 – seven hundred fifty thousand dollars ($750,000);

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

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

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

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

(B) The provisions of this subsection shall not prevent a health insurance carrier and a health benefit plan from placing annual dollar limits for any individual on specific covered

1 benefits that are not essential health benefits to the extent that such limits are otherwise permitted
2 under applicable federal law or the laws and regulations of this state.
3 (3) In determining whether an individual has received benefits that meet or exceed the
4 allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier and a
5 health benefit plan shall take into account only essential health benefits.
6 (b) Lifetime limits.
7 (1)A health insurance carrier and health benefit plan offering group or individual health
8 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
9 benefits, as designated pursuant to a state determination and in accordance with federal laws and
10 regulations, for any individual.
11 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
12 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
13 benefits that are not essential health benefits, as designated pursuant to a state determination and
14 in accordance with federal laws and regulations.
15 (c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this
16 subsection, this subsection applies to any individual:
17 (A) Whose coverage or benefits under a health plan ended by reason of reaching a
18 lifetime limit on the dollar value of all benefits for the individual; and
19 (B) Who, due to the provisions of this section, becomes eligible, or is required to become
20 eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the
21 health benefit plan:
22 (i) For group health insurance coverage, on the first day of the first plan year beginning
23 on or after September 23, 2010; or
24 (ii) For individual health insurance coverage, on the first day of the first policy year
25 beginning on or after September 23, 2010.
26 (2) For individual health insurance coverage, an individual is not entitled to reinstatement
27 under the health benefit plan under this subsection if the individual reached his or her lifetime
28 limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection
29 applies to a family member who reached his or her lifetime limit in a family plan and other family
30 members remain covered under the plan.
31 (3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to
32 become eligible for benefits, the health insurance carrier and health benefit plan shall provide the
33 individual written notice that:
34 (i) The lifetime limit on the dollar value of all benefits no longer applies; and

1 (ii) The individual, if still covered under the plan, is again eligible to receive benefits
2 under the plan.
3 (B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for,
4 but not enrolled in any benefit package under the plan, the health insurance carrier and health
5 benefit plan shall provide an opportunity for the individual to enroll in the plan for a period of at
6 least thirty (30) days.
7 (C) The notices and enrollment opportunity under this subdivision shall be provided
8 beginning not later than:
9 (i) For group health insurance coverage, the first day of the first plan year beginning on
10 or after September 23, 2010;
11 (ii) For individual health insurance coverage, the first day of the first policy year
12 beginning on or after September 23, 2010; or
13 (iii) The notices required under this subsection shall be provided:
14 (I) For group health insurance coverage, to an employee on behalf of the employee's
15 dependent; or
16 (II) For individual health insurance coverage, to the primary subscriber on behalf of the
17 primary subscriber's dependent.
18 (D) For group health insurance coverage, the notices may be included with other
19 enrollment materials that a health plan distributes to employees, provided the statement is
20 prominent. For group health insurance coverage, if a notice satisfying the requirements of this
21 subsection is provided to an individual, a health insurance carrier's requirement to provide the
22 notice with respect to that individual is satisfied.
23 (E) For any individual who enrolls in a health plan in accordance with subdivision (2) of
24 this subsection, coverage under the plan shall take effect not later than:
25 (i) For group health insurance coverage, the first day of the first plan year beginning on
26 or after September 23, 2010; or
27 (ii) For individual health insurance coverage, the first day of the first policy year
28 beginning on or after September 23, 2010.
29 (d)(1) An individual enrolling in a health plan for group health insurance coverage in
30 accordance with subsection (c) above shall be treated as if the individual were a special enrollee
31 as provided under regulations interpreting the HIPAA portability provisions issued pursuant to
32 Section 2714 of the Affordable Care Act.
33 (2) An individual enrolling in accordance with subsection (c) above:
34 (A) Shall be offered all of the benefit packages available to similarly situated individuals

1 who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value
2 of all benefits; and
3 (B) Shall not be required to pay more for coverage than similarly situated individuals
4 who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all
5 benefits.
6 (3) For purposes of subsection (B)(1), any difference in benefits or cost-sharing
7 constitutes a different benefit package.
8 (e)(1) The provisions of this section relating to lifetime limits apply to any health
9 insurance carrier providing coverage under an individual or group health plan, including
10 grandfathered health plans.
11 (2) The provisions of this section relating to annual limits apply to any health insurance
12 carrier providing coverage under a group health plan, including grandfathered health plans, but
13 the prohibition and limits on annual limits do not apply to grandfathered health plans providing
14 individual health insurance coverage.
15 **27-18-80. Coverage for preventive items and services. –** (a) Every health insurance
16 carrier providing coverage under an individual or group health plan shall provide coverage for all
17 of the following items and services, and shall not impose any cost-sharing requirements, such as a
18 copayment, coinsurance or deductible, with respect to the following items and services:
19 (1) Except as otherwise provided in subsection (b) of this section, and except as may
20 otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-
21 based items or services that have in effect a rating of A or B in the recommendations of the
22 United States Preventive Services Task Force as of September 23, 2010 and as may subsequently
23 be amended.
24 (2) Immunizations for routine use in children, adolescents and adults that have in effect a
25 recommendation from the Advisory Committee on Immunization Practices of the Centers for
26 Disease Control and Prevention with respect to the individual involved. For purposes of this
27 subdivision, a recommendation from the Advisory Committee on Immunization Practices of the
28 Centers for Disease Control and Prevention is considered in effect after it has been adopted by the
29 Director of the Centers for Disease Control and Prevention, and a recommendation is considered
30 to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease
31 Control and Prevention.
32 (3) With respect to infants, children and adolescents, evidence-informed preventive care,
33 and screenings provided for in comprehensive guidelines supported by the Health Resources and
34 Services Administration.

1 (4) With respect to women, to the extent not described in subdivision (1) of this
2 subsection, evidence-informed preventive care and screenings provided for in comprehensive
3 coverage guidelines supported by the Health Resources and Services Administration.
4 (b)(1) A health insurance carrier is not required to provide coverage for any items or
5 services specified in any recommendation or guideline described in subsection (a) of this section
6 after the recommendation or guideline is no longer described in subsection (a) of this section. The
7 provisions of this subdivision shall not affect the obligation of the health insurance carrier to
8 provide notice to a covered person before any material modification of coverage becomes
9 effective, in accordance with other requirements of state and federal law, including section
10 2715(d)(4) of the Public Health Services Act.
11 (2) A health insurance carrier shall at least annually at the beginning of each new plan
12 year or policy year, whichever is applicable, revise the preventive services covered under its
13 health benefit plans pursuant to this section consistent with the recommendations of the United
14 States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the
15 Centers for Disease Control and Prevention and the guidelines with respect to infants, children,
16 adolescents and women evidence-based preventive care and screenings by the Health Resources
17 and Services Administration in effect at the time.
18 (c)(1) A health insurance carrier may impose cost-sharing requirements with respect to an
19 office visit if an item or service described in subsection (a) of this section is billed separately or is
20 tracked as individual encounter data separately from the office visit.
21 (2) A health insurance carrier shall not impose cost-sharing requirements with respect to
22 an office visit if an item or service described in subsection (a) of this section is not billed
23 separately or is not tracked as individual encounter data separately from the office visit and the
24 primary purpose of the office visit is the delivery of the item or service described in subsection
25 (a) of this section.
26 (3) A health insurance carrier may impose cost-sharing requirements with respect to an
27 office visit if an item or service described in subsection (a) of this section is not billed separately
28 or is not tracked as individual encounter data separately from the office visit and the primary
29 purpose of the office visit is not the delivery of the item or service.
30 (d)(1) Nothing in this section requires a health insurance carrier that has a network of
31 providers to providing coverage for items and services described in subsection (a) of this section
32 that are delivered by an out-of-network provider.
33 (2) Nothing in subsection (a) of this section precludes a health insurance carrier that has a
34 network of providers from imposing cost-sharing requirements for items or services described in

1 subsection (a) of this section that are delivered by an out-of-network provider.

2 (e) Nothing prevents a health insurance carrier from using reasonable medical
3 management techniques to determine the frequency, method, treatment or setting for an item or
4 service described in subsection (a) of this section to the extent not specified in the
5 recommendation or guideline.

6 (f) Nothing in this section prohibits a health insurance carrier from providing coverage
7 for items and services in addition to those recommended by the United States Preventive Services
8 Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease
9 Control and Prevention, or provided by guidelines supported by the Health Resources and
10 Services Administration, or from denying coverage for items and services that are not
11 recommended by that task force or that advisory committee, or under those guidelines. A health
12 insurance carrier may impose cost-sharing requirements for a treatment not described in
13 subsection (a) of this section even if the treatment results from an item or service described in
14 subsection (a) of this section.

15 (g) This section shall not apply to grandfathered health plans.

16 **27-18-81. Coverage for individuals participating in approved clinical trials. –** (a) As
17 used in this section,

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

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

23 (i) The National Institutes of Health;

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

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

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

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

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

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

1 (I) Is comparable to the system of peer review of studies and investigations used by the
2 National Institutes of Health; and
3 (II) Assures unbiased review of the highest scientific standards by qualified individuals
4 who have no interest in the outcome of the review.
5 (B) The study or investigation is conducted under an investigational new drug application
6 reviewed by the Food and Drug Administration; or
7 (C) The study or investigation is a drug trial that is exempt from having such an
8 investigational new drug application.
9 (2) "Participant" has the meaning stated in section 3(7) of ERISA.
10 (3) "Participating provider" means a health care provider that, under a contract with the
11 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
12 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
13 deductibles, directly or indirectly from the health carrier.
14 (4) "Qualified individual" means a participant or beneficiary who meets the following
15 conditions:
16 (A) The individual is eligible to participate in an approved clinical trial according to the
17 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;
18 and
19 (B)(i) The referring health care professional is a participating provider and has concluded
20 that the individual's participation in such trial would be appropriate based on the individual
21 meeting the conditions described in subdivision (A) of this subdivision (3); or
22 (ii) The participant or beneficiary provides medical and scientific information
23 establishing the individual's participation in such trial would be appropriate based on the
24 individual meeting the conditions described in subdivision (A) of this subdivision (3).
25 (5) "Life-threatening condition" means any disease or condition from which the
26 likelihood of death is probable unless the course of the disease or condition is interrupted.
27 (b)(1) If a health insurance carrier offering group or individual health insurance coverage
28 provides coverage to a qualified individual, the health insurance carrier:
29 (A) Shall not deny the individual participation in an approved clinical trial.
30 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose
31 additional conditions on the coverage of routine patient costs for items and services furnished in
32 connection with participation in the approved clinical trial; and
33 (C) Shall not discriminate against the individual on the basis of the individual's
34 participation in the approved clinical trial.

1 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all
2 items and services consistent with the coverage typically covered for a qualified individual who is
3 not enrolled in an approved clinical trial.
4 (B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not
5 include:
6 (i) The investigational item, device or service itself;
7 (ii) Items and services that are provided solely to satisfy data collection and analysis
8 needs and that are not used in the direct clinical management of the patient; or
9 (iii) A service that is clearly inconsistent with widely accepted and established standards
10 of care for a particular diagnosis.
11 (3) If one or more participating providers are participating in a clinical trial, nothing in
12 subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring
13 that a qualified individual participate in the trial through such a participating provider if the
14 provider will accept the individual as a participant in the trial.
15 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection
16 shall apply to a qualified individual participating in an approved clinical trial that is conducted
17 outside this state.
18 (5) This section shall not be construed to require a health insurance carrier offering group
19 or individual health insurance coverage to provide benefits for routine patient care services
20 provided outside of the coverage's health care provider network unless out-of-network benefits
21 are otherwise provided under the coverage.
22 (6) Nothing in this section shall be construed to limit a health insurance carrier's
23 coverage with respect to clinical trials.
24 (c) The requirements of this section shall be in addition to the requirements of Rhode
25 Island general laws sections 27-18-36 through 27-18-36.3.
26 (d) This section shall not apply to grandfathered health plans.
27 (e) This section shall be effective for plan years beginning on or after January 1, 2014.
28 **27-18-82. Medical loss ratio rebates. –** (a) A health insurance carrier offering group or
29 individual health insurance coverage, including a grandfathered health plan, shall pay medical
30 loss ratio rebates as provided for in Section 2718(b)(1)(A) of the Affordable Care Act, in the
31 manner and as required by federal laws and regulations.
32 (b) Health insurance carriers required to report medical loss ratio and rebate calculations
33 and other medical loss ratio and rebate information to the U.S. Department of Health and Human
34 Services shall concurrently file such information with the commissioner.

1 **27-18-83. Emergency services. –** (a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Applicable cost-sharing.

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

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

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

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

(2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency

1 services provided out of network if the cost-sharing requirement generally applies to out-of-
2 network benefits. A deductible may be imposed with respect to out-of-network emergency
3 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
4 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
5 apply to out-of-network emergency services.
6 (e) The provisions of this section apply for plan years beginning on or after September
7 23, 2010.
8 (f) This section shall not apply to grandfathered health plans.
9 **27-18-84. Internal and external appeal of adverse benefit determinations. –** (a) The
10 commissioner shall adopt regulations to implement standards and procedures with respect to
11 internal claims and appeals of adverse benefit determinations, and with respect to external appeals
12 of adverse benefit determinations.
13 (b) The regulations adopted by the commissioner shall apply to those adverse benefit
14 determinations within the jurisdiction of the commissioner.
15 SECTION 3. Sections 27-18-8, 27-18-44 and 27-18-59 of the General laws in Chapter
16 27-18 entitled "Accident and Sickness Insurance Policies" are hereby amended to read as follows:
17 **27-18-8. Filing of accident and sickness insurance policy forms. --** Any insurance
18 company authorized to do an accident and sickness business within this state in accordance with
19 the provisions of this title shall file all accident and sickness insurance policy forms and rates
20 used by it in the state with the insurance commissioner, including the forms of any rider,
21 endorsement, application blank, and other matter generally used or incorporated by reference in
22 its policies or contracts of insurance. No such rate shall be used unless first approved by the
23 commissioner. No such form shall be used if disapproved by the commissioner under this section,
24 or if the commissioner's approval has been withdrawn under section 27-18-8.3, or until the
25 expiration of the waiting period established under section 27-18-8.3. Such a company shall
26 comply with its filed and approved rates and forms. If the commissioner finds from an
27 examination of any form that it is contrary to the public interest, or the requirements of this code
28 or duly promulgated regulations, he or she shall forbid its use, and shall notify the company in
29 writing as provided in section 27-18-8.2. Each form shall include a certification by a qualified
30 actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance
31 with applicable laws and that the benefits are reasonable in relation to the premium to be charged.
32 **27-18-44. Primary and preventive obstetric and gynecological care. –** (a) Any insurer
33 or health plan, nonprofit health medical service plan, or nonprofit hospital service plan that
34 provides coverage for obstetric and gynecological care for issuance or delivery in the state to any

1 group or individual on an expense-incurred basis, including a health plan offered or issued by a
2 health insurance carrier or a health maintenance organization, shall permit a woman to receive an
3 annual visit to an in-network obstetrician/gynecologist for routine gynecological care without
4 requiring the woman to first obtain a referral from a primary care provider.
5 (b)(1)(A) Any health plan, nonprofit medical service plan or nonprofit hospital service
6 plan, including a health insurance carrier or a health maintenance organization which requires or
7 provides for the designation by a covered person of a participating primary health care
8 professional shall permit each covered person to:
9 (i) Designate any participating primary care health care professional who is available to
10 accept the covered person; and
11 (ii) For a child, designate any participating physician who specializes in pediatrics as the
12 child's primary care health care professional and is available to accept the child.
13 (2) The provisions of subdivision (1) of this subsection shall not be construed to waive
14 any exclusions of coverage under the terms and conditions of the health benefit plan with respect
15 to coverage of pediatric care.
16 (c)(1) If a health plan, nonprofit medical service plan or nonprofit hospital service plan,
17 including a health insurance carrier or a health maintenance organization, provides coverage for
18 obstetrical or gynecological care and requires the designation by a covered person of a
19 participating primary care health care professional, then it:
20 (A) Shall not require any person's, including a primary care health care professional's,
21 prior authorization or referral in the case of a female covered person who seeks coverage for
22 obstetrical or gynecological care provided by a participating health care professional who
23 specializes in obstetrics or gynecology; and
24 (B) Shall treat the provision of obstetrical and gynecological care, and the ordering of
25 related obstetrical and gynecological items and services, pursuant to subdivision (A) of this
26 subdivision (c)(1), by a participating health care professional who specializes in obstetrics or
27 gynecology as the authorization of the primary care health care professional.
28 (2)(A) A health plan, nonprofit medical service plan or nonprofit hospital service plan,
29 including a health insurance carrier or a health maintenance organization may require the health
30 care professional to agree to otherwise adhere to its policies and procedures, including procedures
31 relating to referrals, obtaining prior authorization, and providing services in accordance with a
32 treatment plan, if any, approved by the plan, carrier or health maintenance organization.
33 (B)For purposes of subdivision (A) of this subdivision (c)(1), a health care professional,
34 who specializes in obstetrics or gynecology, means any individual, including an individual other

1 than a physician, who is authorized under state law to provide obstetrical or gynecological care.

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

3 (A) Waive any exclusions of coverage under the terms and conditions of the health

4 benefit plan with respect to coverage of obstetrical or gynecological care; or

5 (B) Preclude the health plan, nonprofit medical service plan or nonprofit hospital service

6 plan, including a health insurance carrier or a health maintenance organization involved from

7 requiring that the participating health care professional providing obstetrical or gynecological

8 care notify the primary care health care professional or the plan, carrier or health maintenance

9 organization of treatment decisions.

10 (d) Notice Requirements:

11 (1) A health plan, nonprofit medical service plan or nonprofit hospital service plan,

12 including a health insurance carrier or a health maintenance organization subject to this section

13 shall provide notice to covered persons of the terms and conditions of the plan related to the

14 designation of a participating health care professional and of a covered person's rights with

15 respect to those provisions.

16 (2)(A) In the case of group health insurance coverage, the notice described in subdivision

17 (1) of this subsection shall be included whenever the a participant is provided with a summary

18 plan description or other similar description of benefits under the health benefit plan.

19 (B) In the case of individual health insurance coverage, the notice described in

20 subdivision (1) of this subsection shall be included whenever the primary subscriber is provided

21 with a policy, certificate or contract of health insurance.

22 (C) A health plan, nonprofit medical service plan or nonprofit hospital service plan,

23 including a health insurance carrier or a health maintenance organization, may use the model

24 language in 45 CFR section 147.138(a)(4)(iii) to satisfy the requirements of this subsection.

25 (e) The requirements of subsections (b), (c), and (d) shall not apply to grandfathered

26 health plans.

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

28 (a)(1) Every individual health insurance contract, plan, or policy delivered, issued for delivery, or

29 renewed in this state and every group health insurance contract, plan, or policy delivered, issued

30 for delivery or renewed in this state which provides ~~medical~~ health benefits coverage for

31 ~~dependent children that includes coverage for physician services in a physician's office, and every~~

32 ~~policy which provides major medical or similar comprehensive type coverage~~ dependents, except

33 for supplemental policies which only provide coverage for specified diseases and other

34 supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried child under the age~~

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

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

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

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

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

(b)(1) This subsection applies to any child:

1 (A) Whose coverage ended, or who was denied coverage, or was not eligible for group
2 health insurance coverage or individual health insurance coverage under a health benefit plan
3 because, under the terms of coverage, the availability of dependent coverage of a child ended
4 before the attainment of twenty-six (26) years of age; and
5 (B) Who becomes eligible, or is required to become eligible, for coverage on the first day
6 of the first plan year and, in the individual market, the first day of the first policy year, beginning
7 on or after September 23, 2010 by reason of the provisions of this section.
8 (2)(A) If group health insurance coverage or individual health insurance coverage, in
9 which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in
10 which the child's coverage ended or did not begin for the reasons described in subdivision (1) of
11 this subsection, and if the health insurance carrier is subject to the requirements of this section the
12 health insurance carrier shall give the child an opportunity to enroll that continues for at least
13 sixty (60) days, including the written notice of the opportunity to enroll as described subdivision
14 (3) of this subsection.
15 (B) The health insurance carrier shall provide the opportunity to enroll, including the
16 written notice beginning not later than the first day of the first plan year and in the individual
17 market the first day of the first policy year, beginning on or after September 23, 2010.
18 (3)(A) The written notice of opportunity to enroll shall include a statement that children
19 whose coverage ended, or who were denied coverage, or were not eligible for coverage, because
20 the availability of dependent coverage of children ended before the attainment of twenty-six (26)
21 years of age are eligible to enroll in the coverage.
22 (B)(i) The notice may be provided to an employee on behalf of the employee's child and,
23 in the individual market, to the primary subscriber on behalf of the primary subscriber's child.
24 (ii) For group health insurance coverage:
25 (I)The notice may be included with other enrollment materials that the health carrier
26 distributes to employees, provided the statement is prominent; and
27 (II) If a notice satisfying the requirements of this subdivision is provided to an employee
28 whose child is entitled to an enrollment opportunity under subsection (c) of this section, the
29 obligation to provide the notice of enrollment opportunity under subdivision (B) of this
30 subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.
31 (C) The written notice shall be provided beginning not later than the first day of the first
32 plan year and in the individual market the first day of the first policy year, beginning on or after
33 September 23, 2010.
34 (4) For an individual who enrolls under this subsection, the coverage shall take effect not

later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

(c)(1) A child enrolling in group health insurance coverage pursuant to subsections (b) and (c) of this section shall be treated as if the child were a special enrollee, as provided under regulations interpreting the Health Insurance Portability and Accountability Act ("HIPAA") portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

(2)(A) The child and, if the child would not be a participant once enrolled, the participant through whom the child is otherwise eligible for coverage under the plan, shall be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(B) For purposes of this subdivision (2), any difference in benefits or cost-sharing requirements constitutes a different benefit package.

(3) The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

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

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

(3) The provisions of this section shall apply to policy years in the individual market on and after September 23, 2010.

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

SECTION 4. Sections 27-19-1 and 27-19-50 of the General laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" are hereby amended to read as follows:

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

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

1 hospital service plan operated by the corporation;

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

12 (3) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010,
13 as amended by the Health Care and Education Reconciliation Act of 2010.

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

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

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

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

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

27 (9) “Health benefits” or “covered benefits” means medical, surgical, hospital,
28 prescription drug, and such other benefits, whether self-funded, or delivered through the purchase
29 of insurance or otherwise;

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

34 (11) "Health care professional" means a physician or other health care practitioner

licensed, accredited or certified to perform specified health care services consistent with state law;

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

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

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

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

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

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

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

(iv) Workers’ compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

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

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

(i) Limited scope dental or vision benefits.

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

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

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

~~(3)~~(16) "Nonprofit hospital service corporation" means any corporation organized pursuant to this chapter for the purpose of establishing, maintaining, and operating a nonprofit hospital service plan;

~~(4)~~(17) "Nonprofit hospital service plan" means a plan by which specified hospital care is to be provided to subscribers to the plan by a contracting hospital; ~~and~~

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

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

~~(5)~~(20) "Subscribers" mean those persons, whether or not residents of this state, who have contracted with a nonprofit hospital service corporation for hospital care pursuant to a nonprofit hospital service plan operated by the corporation.

27-19-50. ~~Termination of children's benefits~~ Eligibility for children's benefits. -- (a) (1) Every individual health insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state and every group health insurance contract, plan, or policy delivered, issued for delivery or renewed in this state which provides ~~medical~~ health benefits coverage ~~for dependent children that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage~~ dependents, except for supplemental policies which only provide coverage for specified diseases and other supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried child under the age~~

~~of nineteen (19) years, an unmarried child who is a student under the age of twenty-five (25) years and who is financially dependent upon the parent and an unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months~~ for children until attainment of twenty-six (26) years of age. ~~Such contract, plan or policy shall also include a provision that policyholders shall receive no less than thirty (30) days notice from the nonprofit hospital service corporation that a child covered as a dependent by the policyholder is about to lose his or her coverage as a result of reaching the maximum age for a dependent child and that the child will only continue to be covered upon documentation being provided of current full or part-time enrollment in a post-secondary educational institution, or that the child may purchase a conversion policy if he or she is not an eligible student.~~

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

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

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

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

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

1 (b)(1) This subsection applies to any child:

2 (A) Whose coverage ended, or who was denied coverage, or was not eligible for group
3 health insurance coverage or individual health insurance coverage under a health benefit plan
4 because, under the terms of coverage, the availability of dependent coverage of a child ended
5 before the attainment of twenty-six (26) years of age; and

6 (B) Who becomes eligible, or is required to become eligible, for coverage on the first day
7 of the first plan year and, in the individual market, the first day of the first policy year, beginning
8 on or after September 23, 2010 by reason of the provisions of this section.

9 (2)(A) If group health insurance coverage or individual health insurance coverage, in
10 which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in
11 which the child's coverage ended or did not begin for the reasons described in subdivision (1) of
12 this subsection, and if the health insurance carrier is subject to the requirements of this section the
13 health insurance carrier shall give the child an opportunity to enroll that continues for at least
14 sixty (60) days, including the written notice of the opportunity to enroll as described subdivision
15 (3) of this subsection.

16 (B) The health insurance carrier shall provide the opportunity to enroll, including the
17 written notice beginning not later than the first day of the first plan year and in the individual
18 market the first day of the first policy year, beginning on or after September 23, 2010.

19 (3)(A) The written notice of opportunity to enroll shall include a statement that children
20 whose coverage ended, or who were denied coverage, or were not eligible for coverage, because
21 the availability of dependent coverage of children ended before the attainment of twenty-six (26)
22 years of age are eligible to enroll in the coverage.

23 (B)(i) The notice may be provided to an employee on behalf of the employee's child and,
24 in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

25 (ii) For group health insurance coverage:

26 (I) The notice may be included with other enrollment materials that the health carrier
27 distributes to employees, provided the statement is prominent; and

28 (II) If a notice satisfying the requirements of this subdivision is provided to an employee
29 whose child is entitled to an enrollment opportunity under subsection (b) of this section, the
30 obligation to provide the notice of enrollment opportunity under subdivision (B) of this
31 subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.

32 (C) The written notice shall be provided beginning not later than the first day of the first
33 plan year and in the individual market the first day of the first policy year, beginning on or after
34 September 23, 2010.

(4) For an individual who enrolls under this subsection, the coverage shall take effect not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

(c)(1) A child enrolling in group health insurance coverage pursuant to subsection (b) of this section shall be treated as if the child were a special enrollee, as provided under regulations interpreting the HIPAA portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

(2)(A) The child and, if the child would not be a participant once enrolled, the participant through whom the child is otherwise eligible for coverage under the plan, shall be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(B) For purposes of this subdivision (2), any difference in benefits or cost-sharing requirements constitutes a different benefit package.

(3) The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

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

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

(3) The provision of this section applies to policy years in the individual market on and after September 23, 2010, and shall apply to grandfathered health plans.

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

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

27-19-7.1. Uniform explanation of benefits and coverage. – (a) A nonprofit hospital service corporation shall provide a uniform summary of benefits and coverage explanation and

1 standardized definitions to policyholders and others required by, and at the times required by, the
2 federal regulations adopted under section 2715 of the Affordable Care Act. A summary required
3 by this section shall be filed with the commissioner for approval under Rhode Island general laws
4 section 27-19-7.2. The requirements of this section shall be in addition to the requirements of
5 Rhode Island general laws section 27-19-7.2. The commissioner may waive one or more of the
6 requirements of the regulations adopted under section 2715 of the Affordable Care Act for good
7 cause shown. The summary must contain at least the following information:
8 (1) Uniform definitions of standard insurance and medical terms.
9 (2) A description of coverage and cost-sharing for each category of essential benefits and
10 other benefits.
11 (3) Exceptions, reductions and limitations in coverage.
12 (4) Renewability and continuation of coverage provisions.
13 (5) A "coverage facts label" that illustrates coverage under common benefits scenarios.
14 (6) A statement of whether the policy, contract or plan provides the minimum coverage
15 required of a qualified health plan.
16 (7) A statement that the outline is a summary and that the actual policy language should
17 be consulted; and
18 (8) A contact number for the consumer to call with additional questions and the web
19 address of where the actual language of the policy, contract or plan can be found.
20 (b) The provisions of this section shall apply to grandfathered health plans.
21 **27-19-7.2. Filing of policy forms. –** A nonprofit hospital service corporation shall file all
22 policy forms and rates used by it in the state with the commissioner, including the forms of any
23 rider, endorsement, application blank, and other matter generally used or incorporated by
24 reference in its policies or contracts of insurance. No such rate shall be used unless first approved
25 by the commissioner. No such form shall be used if disapproved by the commissioner under this
26 section, or if the commissioner's approval has been withdrawn after notice and an opportunity to
27 be heard, or until the expiration of sixty (60) days following the filing of the form. A nonprofit
28 hospital service corporation shall comply with its filed and approved rates and forms. If the
29 commissioner finds from an examination of any form that it is contrary to the public interest, or
30 the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and
31 shall notify the corporation in writing. Each form shall include a certification by a qualified
32 actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance
33 with applicable laws and that the benefits are reasonable in relation to the premium to be charged.
34 **27-19-62. Prohibition on rescission of coverage. –** (a)(1) Coverage under a health plan

1 subject to the jurisdiction of the commissioner under this chapter with respect to an individual,
2 including a group to which the individual belongs or family coverage in which the individual is
3 included, shall not be rescinded after the individual is covered under the plan, unless:
4 (A) The individual or a person seeking coverage on behalf of the individual, performs an
5 act, practice or omission that constitutes fraud; or
6 (B) The individual makes an intentional misrepresentation of material fact, as prohibited
7 by the terms of the plan or coverage.
8 (2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an
9 individual does not include an insurance producer or employee or authorized representative of the
10 health carrier.
11 (b) At least thirty (30) days advance written notice shall be provided to each health
12 benefit plan enrollee or, for individual health insurance coverage, primary subscriber, who would
13 be affected by the proposed rescission of coverage before coverage under the plan may be
14 rescinded in accordance with subsection (a) regardless of, in the case of group health insurance
15 coverage, whether the rescission applies to the entire group or only to an individual within the
16 group.
17 (c) For purposes of this section, "to rescind" means to cancel or to discontinue coverage
18 with retroactive effect for reasons unrelated to timely payment of required premiums or
19 contribution to costs of coverage.
20 (d) This section applies to grandfathered health plans.
21 **27-19-63. Prohibition on annual and lifetime limits. –** (a) Annual limits. (1) For plan or
22 policy years beginning prior to January 1, 2014, for any individual, a health insurance carrier and
23 health benefit plan subject to the jurisdiction of the commissioner under this chapter may
24 establish an annual limit on the dollar amount of benefits that are essential health benefits
25 provided the restricted annual limit is not less than the following:
26 (A) For a plan or policy year beginning after September 22, 2010, but before September
27 23, 2011 – seven hundred fifty thousand dollars ($750,000);
28 (B) For a plan or policy year beginning after September 22, 2011, but before September
29 23, 2012 – one million two hundred fifty thousand dollars ($1,250,000); and
30 (C) For a plan or policy year beginning after September 22, 2012, but before January 1,
31 2014 – two million dollars ($2,000,000).
32 (2) For plan or policy years beginning on or after January 1, 2014, a health insurance
33 carrier and health benefit plan shall not establish any annual limit on the dollar amount of
34 essential health benefits for any individual, except:

1 (A) A health flexible spending arrangement, as defined in Section 106(c)(2)(i) of the
2 Internal Revenue Code, a medical savings account, as defined in Section 220 of the Internal
3 Revenue Code, and a health savings account, as defined in Section 223 of the Internal Revenue
4 Code, are not subject to the requirements of subdivisions (1) and (2) of this subsection .
5 (B) The provisions of this subsection shall not prevent a health insurance carrier and
6 health benefit plan from placing annual dollar limits for any individual on specific covered
7 benefits that are not essential health benefits to the extent that such limits are otherwise permitted
8 under applicable federal law or the laws and regulations of this state.
9 (3) In determining whether an individual has received benefits that meet or exceed the
10 allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier and
11 health benefit plan shall take into account only essential health benefits.
12 (b) Lifetime limits.
13 (1) A health insurance carrier and health benefit plan offering group or individual health
14 insurance coverage shall not establish a lifetime limit on-the-dollar-value of essential health
15 benefits, as designated pursuant to a state determination and in accordance with federal laws and
16 regulations, for any individual.
17 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
18 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
19 benefits that are not essential health benefits, as designated pursuant to a state determination and
20 in accordance with federal laws and regulations.
21 (c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this
22 subsection, this subsection applies to any individual:
23 (A) Whose coverage or benefits under a health plan ended by reason of reaching a
24 lifetime limit on the dollar value of all benefits for the individual; and
25 (B) Who, due to the provisions of this section, becomes eligible, or is required to become
26 eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the
27 health benefit plan:
28 (i) For group health insurance coverage, on the first day of the first plan year beginning
29 on or after September 23, 2010; or
30 (ii) For individual health insurance coverage, on the first day of the first policy year
31 beginning on or after September 23, 2010.
32 (2) For individual health insurance coverage, an individual is not entitled to reinstatement
33 under the health benefit plan under this subsection if the individual reached his or her lifetime
34 limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection

1 applies to a family member who reached his or her lifetime limit in a family plan and other family
2 members remain covered under the plan.
3 (3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to
4 become eligible for benefits under the health benefit plan, the health carrier shall provide the
5 individual written notice that:
6 (i) The lifetime limit on the dollar value of all benefits no longer applies; and
7 (ii) The individual, if still covered under the plan, is again eligible to receive benefits
8 under the plan.
9 (B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for,
10 but not enrolled in any benefit package under the plan, the health benefit plan shall provide an
11 opportunity for the individual to enroll in the plan for a period of at least thirty (30) days.
12 (C) The notices and enrollment opportunity under this subdivision shall be provided
13 beginning not later:
14 (i) For group health insurance coverage, the first day of the first plan year beginning on
15 or after September 23, 2010; or
16 (ii) For individual health insurance coverage, the first day of the first policy year
17 beginning on or after September 23, 2010.
18 (iii) The notices required under this subsection shall be provided:
19 (I)For group health insurance coverage, to an employee on behalf of the employee's
20 dependent; or
21 (II) For individual health insurance coverage, to the primary subscriber on behalf of the
22 primary subscriber's dependent.
23 (D) For group health insurance coverage, the notices may be included with other
24 enrollment materials that a health plan distributes to employees, provided the statement is
25 prominent. For group health insurance coverage, if a notice satisfying the requirements of this
26 subsection is provided to an individual, a health insurance carrier's requirement to provide the
27 notice with respect to that individual is satisfied.
28 (E) For any individual who enrolls in a health plan in accordance with subdivision (2) of
29 this subsection, coverage under the plan shall take effect not later than:
30 (i) For group health insurance coverage, the first day of the first plan year beginning on
31 or after September 23, 2010; or
32 (ii) For individual health insurance coverage, the first day of the first policy year
33 beginning on or after September 23, 2010.
34 (d)(1) An individual enrolling in a health plan for group health insurance coverage in

1 accordance with subsection (c) of this subsection shall be treated as if the individual were a
2 special enrollee in the plan, as provided under regulations interpreting the HIPAA portability
3 provisions issued pursuant to Section 2714 of the Affordable Care Act.
4 (2) An individual enrolling in accordance with subsection (c) of this subsection:
5 (A) shall be offered all of the benefit packages available to similarly situated individuals
6 who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value
7 of all benefits; and
8 (B) Shall not be required to pay more for coverage than similarly situated individuals
9 who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all
10 benefits.
11 (3) For purposes of subsection B(1), any difference in benefits or cost-sharing constitutes
12 a different benefit package.
13 (e)(1) The provisions of this section relating to lifetime limits apply to any health
14 insurance carrier providing coverage under an individual or group health plan, including
15 grandfathered health plans.
16 (2) The provisions of this section relating to annual limits apply to any health insurance
17 carrier providing coverage under a group health plan, including grandfathered health plans, but
18 the prohibition and limits on annual limits do not apply to grandfathered health plans providing
19 individual health insurance coverage.
20 **27-19-64. Coverage for preventive items and services. –** (a) Every health insurance
21 carrier providing coverage under an individual or group health plan shall provide coverage for all
22 of the following items and services, and shall not impose any cost-sharing requirements, such as a
23 copayment, coinsurance or deductible, with respect to the following items and services:
24 (1) Except as otherwise provided in subsection (b) of this section, and except as may
25 otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-
26 based items or services that have in effect a rating of A or B in the recommendations of the
27 United States Preventive Services Task Force as of September 23, 2010, and as may subsequently
28 be amended.
29 (2) Immunizations for routine use in children, adolescents and adults that have in effect a
30 recommendation from the Advisory Committee on Immunization Practices of the Centers for
31 Disease Control and Prevention with respect to the individual involved. For purposes of this
32 subdivision, a recommendation from the Advisory Committee on Immunization Practices of the
33 Centers for Disease Control and Prevention is considered in effect after it has been adopted by the
34 Director of the Centers for Disease Control and Prevention, and a recommendation is considered

1 to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease
2 Control and Prevention.
3 (3) With respect to infants, children and adolescents, evidence-informed preventive care,
4 and screenings provided for in comprehensive guidelines supported by the Health Resources and
5 Services Administration.
6 (4) With respect to women, to the extent not described in subdivision (1) of this
7 subsection, evidence-informed preventive care and screenings provided for in comprehensive
8 coverage guidelines supported by the Health Resources and Services Administration.
9 (b)(1) A health insurance carrier is not required to provide coverage for any items or
10 services specified in any recommendation or guideline described in subsection (a) of this section
11 after the recommendation or guideline is no longer described in subsection (a) of this section. The
12 provisions of this subdivision shall not affect the obligation of the health insurance carrier to
13 provide notice to a covered person before any material modification of coverage becomes
14 effective, in accordance with other requirements of state and federal law, including section
15 2715(d)(4) of the Public Health Services Act.
16 (2) A health insurance carrier shall at least annually at the beginning of each new plan
17 year or policy year, whichever is applicable, revise the preventive services covered under its
18 health benefit plans pursuant to this section consistent with the recommendations of the United
19 States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the
20 Centers for Disease Control and Prevention and the guidelines with respect to infants, children,
21 adolescents and women evidence-based preventive care and screenings by the Health Resources
22 and Services Administration in effect at the time.
23 (c)(1) A health insurance carrier may impose cost-sharing requirements with respect to an
24 office visit if an item or service described in subsection (a) of this section is billed separately or is
25 tracked as individual encounter data separately from the office visit.
26 (2) A health insurance carrier shall not impose cost-sharing requirements with respect to
27 an office visit if an item or service described in subsection (a) of this section is not billed
28 separately or is not tracked as individual encounter data separately from the office visit and the
29 primary purpose of the office visit is the delivery of the item or service described in subsection
30 (a) of this section.
31 (3) A health insurance carrier may impose cost-sharing requirements with respect to an
32 office visit if an item or service described in subsection (a) of this section is not billed separately
33 or is not tracked as individual encounter data separately from the office visit and the primary
34 purpose of the office visit is not the delivery of the item or service.

1 (d)(1) Nothing in this section requires a health insurance carrier that has a network of
2 providers to provide coverage for items and services described in subsection (a) of this section
3 that are delivered by an out-of-network provider.
4 (2) Nothing in subsection (a) of this section precludes a health insurance carrier that has a
5 network of providers from imposing cost-sharing requirements for items or services described in
6 subsection (a) of this section that are delivered by an out-of-network provider.
7 (e) Nothing prevents a health insurance carrier from using reasonable medical
8 management techniques to determine the frequency, method, treatment or setting for an item or
9 service described in subsection (a) of this section to the extent not specified in the
10 recommendation or guideline.
11 (f) Nothing in this section prohibits a health insurance carrier from providing coverage
12 for items and services in addition to those recommended by the United States Preventive Services
13 Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease
14 Control and Prevention, or provided by guidelines supported by the Health Resources and
15 Services Administration, or from denying coverage for items and services that are not
16 recommended by that task force or that advisory committee, or under those guidelines. A health
17 insurance carrier may impose cost-sharing requirements for a treatment not described in
18 subsection (a) of this section even if the treatment results from an item or service described in
19 subsection (a) of this section.
20 (g) This section shall not apply to grandfathered health plans.
21 **27-19-65. Coverage for individuals participating in approved clinical trials. –** (a) As
22 used in this section:
23 (1) “Approved clinical trial” means a phase I, phase II, phase III or phase IV clinical trial
24 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
25 threatening disease or condition and is described in any of the following:
26 (A) The study or investigation is approved or funded, which may include funding through
27 in-kind contributions, by one or more of the following:
28 (i) The National Institutes of Health;
29 (ii) The Centers for Disease Control and Prevention;
30 (iii) The Agency for Health Care Research and Quality;
31 (iv) The Centers for Medicare & Medicaid Services;
32 (v) A cooperative group or center of any of the entities described in items (i) through (iv)
33 or the Department of Defense or the Department of Veteran Affairs;
34 (vi) A qualified non-governmental research entity identified in the guidelines issued by

1 the National Institutes of Health for center support grants; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (d) This section shall not apply to grandfathered health plans.

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

33 **27-19-66. Medical loss ratio rebates. –** (a) A nonprofit hospital service corporation offering group or individual health insurance coverage, including a grandfathered health plan,

1 shall pay medical loss ratio rebates as provided for in Section 2718(b)(1)(A) of the Affordable
2 Care Act, in the manner and as required by federal laws and regulations.
3 (b) Health insurance carriers required to report medical loss ratio and rebate calculations
4 and other medical loss ratio and rebate information to the U.S. Department of Health and Human
5 Services shall concurrently file such information with the commissioner.
6 **27-19-67. Emergency services. –** (a) As used in this section:
7 (1) "Emergency medical condition" means a medical condition manifesting itself by
8 acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
9 possesses an average knowledge of health and medicine, could reasonably expect the absence of
10 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
11 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
12 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
13 part.
14 (2) "Emergency services" means, with respect to an emergency medical condition:
15 (A) A medical screening examination (as required under section 1867 of the Social
16 Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a
17 hospital, including ancillary services routinely available to the emergency department to evaluate
18 such emergency medical condition, and
19 (B) Such further medical examination and treatment, to the extent they are within the
20 capabilities of the staff and facilities available at the hospital, as are required under section 1867
21 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.
22 (3) "Stabilize", with respect to an emergency medical condition has the meaning given in
23 section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).
24 (b) If a nonprofit hospital service corporation provides any benefits to subscribers with
25 respect to services in an emergency department of a hospital, the plan must cover emergency
26 services consistent with the rules of this section.
27 (c) A nonprofit hospital service corporation shall provide coverage for emergency
28 services in the following manner:
29 (1) Without the need for any prior authorization determination, even if the emergency
30 services are provided on an out-of-network basis;
31 (2) Without regard to whether the health care provider furnishing the emergency services
32 is a participating network provider with respect to the services;
33 (3) If the emergency services are provided out of network, without imposing any
34 administrative requirement or limitation on coverage that is more restrictive than the requirements

1 or limitations that apply to emergency services received from in-network providers;

2 (4) If the emergency services are provided out of network, by complying with the cost-

3 sharing requirements of subsection (d) of this section; and

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

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

6 (B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title

7 XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or

8 (C) Applicable cost sharing.

9 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance

10 rate imposed with respect to a participant or beneficiary for out-of-network emergency services

11 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if

12 the services were provided in-network. However, a participant or beneficiary may be required to

13 pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network

14 provider charges over the amount the plan or health insurance carrier is required to pay under

15 subdivision (1) of this subsection. A group health plan or health insurance carrier complies with

16 the requirements of this subsection if it provides benefits with respect to an emergency service in

17 an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of

18 this subdivision (1)(which are adjusted for in-network cost-sharing requirements).

19 (A) The amount negotiated with in-network providers for the emergency service

20 furnished, excluding any in-network copayment or coinsurance imposed with respect to the

21 participant or beneficiary. If there is more than one amount negotiated with in-network providers

22 for the emergency service, the amount described under this subdivision (A) is the median of these

23 amounts, excluding any in-network copayment or coinsurance imposed with respect to the

24 participant or beneficiary. In determining the median described in the preceding sentence, the

25 amount negotiated with each in-network provider is treated as a separate amount (even if the

26 same amount is paid to more than one provider). If there is no per-service amount negotiated with

27 in-network providers (such as under a capitation or other similar payment arrangement), the

28 amount under this subdivision (A) is disregarded.

29 (B) The amount for the emergency service shall be calculated using the same method the

30 plan generally uses to determine payments for out-of-network services (such as the usual,

31 customary, and reasonable amount), excluding any in-network copayment or coinsurance

32 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is

33 determined without reduction for out-of-network cost sharing that generally applies under the

34 plan or health insurance coverage with respect to out-of-network services. Thus, for example, if a

plan generally pays seventy percent (70%) of the usual, customary, and reasonable amount for out-of-network services, the amount in this subdivision (B) for an emergency service is the total, that is, one hundred percent (100%), of the usual, customary, and reasonable amount for the service, not reduced by the thirty percent (30%) coinsurance that would generally apply to out-of-network services (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).

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

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

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

(f) This section shall not apply to grandfathered health plans.

27-19-68. Internal and external appeal of adverse benefit determinations. – (a) The commissioner shall adopt regulations to implement standards and procedures with respect to internal claims and appeals of adverse benefit determinations, and with respect to external appeals of adverse benefit determinations.

(b) The regulations adopted by the commissioner shall apply to those adverse benefit determinations within the jurisdiction of the commissioner.

SECTION 6. Sections 27-20-1 and 27-20-45 of the General laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" are hereby amended to read as follows:

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

(1) Adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan or to receive coverage under a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a

benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The term also includes a rescission of coverage determination.

(2) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

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

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

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

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

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

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

(9) “Health benefits” or “covered benefits” means medical, surgical, hospital, prescription drug, and such other benefits, whether self-funded, or delivered through the purchase of insurance or otherwise.

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

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

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

(13) "Health care services" means services for the diagnosis, prevention, treatment, cure

1 or relief of a health condition, illness, injury or disease.

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

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

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

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

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

16 (iv) Workers’ compensation or similar insurance.

17 (v) Automobile medical payment insurance.

18 (vi) Credit-only insurance.

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

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

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

25 (i) Limited scope dental or vision benefits.

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

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

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

~~(3)~~(16) "Licensed midwife" means any midwife licensed under section 23-13-9;

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

~~(5)~~(18) "Nonprofit medical service corporation" means any corporation organized pursuant hereto for the purpose of establishing, maintaining, and operating a nonprofit medical service plan;

~~(6)~~(19) "Nonprofit medical service plan" means a plan by which specified medical service is provided to subscribers to the plan by a nonprofit medical service corporation;

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

~~(7)~~(21) "Psychiatric and mental health nurse clinical specialist" is an expanded role utilizing independent knowledge and management of mental health and illnesses. The practice includes collaboration with other licensed health care professionals, including, but not limited to, psychiatrists, psychologists, physicians, pharmacists, and nurses;

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

~~(8)~~(23) "Subscribers" means those persons or groups of persons who contract with a nonprofit medical service corporation for medical service pursuant to a nonprofit medical service plan; and

~~(9)~~(24) "Therapist in marriage and family practice" means a person who has been licensed pursuant to section 5-63.2-10.

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

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

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

(3) A nonprofit medical service corporation shall not deny or restrict coverage for a child who has not attained twenty-six (26) years of age based on the presence or absence of the child’s financial dependency upon the participant, primary subscriber or any other person, residency with

1 the participant and in the individual market the primary subscriber, or with any other person,
2 marital status, student status, employment or any combination of those factors. A nonprofit
3 medical service corporation shall not deny or restrict coverage of a child based on eligibility for
4 other coverage, except as provided in (d)(1) of this section.
5 (4) Nothing in this section shall be construed to require a health insurance carrier to make
6 coverage available for the child of a child receiving dependent coverage, unless the grandparent
7 becomes the legal guardian or adoptive parent of that grandchild.
8 (5) The terms of coverage in a health benefit plan offered by a nonprofit medical service
9 corporation r providing dependent coverage of children cannot vary based on age except for
10 children who are twenty-six (26) years of age or older.
11 (b)(1) This subsection applies to any child:
12 (A) Whose coverage ended, or who was denied coverage, or was not eligible for group
13 health insurance coverage or individual health insurance coverage under a health benefit plan
14 because, under the terms of coverage, the availability of dependent coverage of a child ended
15 before the attainment of twenty-six (26) years of age; and
16 (B) Who becomes eligible, or is required to become eligible, for coverage on the first day
17 of the first plan year and, in the individual market, the first day of the first policy year, beginning
18 on or after September 23, 2010 by reason of the provisions of this section.
19 (2)(A) If group health insurance coverage or individual health insurance coverage, in
20 which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in
21 which the child's coverage ended or did not begin for the reasons described in subdivision (1) of
22 this subsection, and if the health insurance carrier is subject to the requirements of this section the
23 health insurance carrier shall give the child an opportunity to enroll that continues for at least
24 sixty (60) days, including the written notice of the opportunity to enroll as described subdivision
25 (3) of this subsection.
26 (B) The health insurance carrier shall provide the opportunity to enroll, including the
27 written notice beginning not later than the first day of the first plan year and in the individual
28 market the first day of the first policy year, beginning on or after September 23, 2010.
29 (3)(A) The written notice of opportunity to enroll shall include a statement that children
30 whose coverage ended, or who were denied coverage, or were not eligible for coverage, because
31 the availability of dependent coverage of children ended before the attainment of twenty-six (26)
32 years of age are eligible to enroll in the coverage.
33 (B)(i) The notice may be provided to an employee on behalf of the employee's child and,
34 in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

1 (ii) For group health insurance coverage:

2 (I)The notice may be included with other enrollment materials that the health carrier
3 distributes to employees, provided the statement is prominent; and

4 (II) If a notice satisfying the requirements of this subdivision is provided to an employee
5 whose child is entitled to an enrollment opportunity under subsection (c) of this section, the
6 obligation to provide the notice of enrollment opportunity under subdivision (B) of this
7 subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.

8 (C) The written notice shall be provided beginning not later than the first day of the first
9 plan year and in the individual market the first day of the first policy year, beginning on or after
10 September 23, 2010.

11 (4) For an individual who enrolls under this subsection, the coverage shall take effect not
12 later than the first day of the first plan year and, in the individual market, the first day of the first
13 policy year, beginning on or after September 23, 2010.

14 (c)(1) A child enrolling in group health insurance coverage pursuant to subsection (b) of
15 this section shall be treated as if the child were a special enrollee, as provided under regulations
16 interpreting the HIPAA portability provisions issued pursuant to Section 2714 of the Affordable
17 Care Act.

18 (2)(A) The child and, if the child would not be a participant once enrolled, the participant
19 through whom the child is otherwise eligible for coverage under the plan, shall be offered all the
20 benefit packages available to similarly situated individuals who did not lose coverage by reason
21 of cessation of dependent status.

22 (B) For purposes of this subdivision (2), any difference in benefits or cost-sharing
23 requirements constitutes a different benefit package.

24 (3) The child shall not be required to pay more for coverage than similarly situated
25 individuals who did not lose coverage by reason of cessation of dependent status.

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

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

1 (3) The provisions of this section apply to policy years in the individual market on and
2 after September 23, 2010.
3 (b)(e) This section does not apply to insurance coverage providing benefits for: (1)
4 hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5)
5 Medicare supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other
6 limited benefit policies.
7 SECTION 7. Chapter 27-20 of the General laws entitled "Nonprofit Medical Service
8 Corporations" is hereby amended by adding thereto the following sections:
9 **27-20-6.1. Uniform explanation of benefits and coverage. –** (a) A nonprofit medical
10 service corporation shall provide a uniform summary of benefits and coverage explanation and
11 standardized definitions to policyholders and others required by, and at the times required by the
12 federal regulations adopted under section 2715 of the Affordable Care Act. The summary
13 required by this section shall be filed with the commissioner for approval under Rhode Island
14 general laws section 27-20-6.2. The requirements of this section shall be in addition to the
15 requirements of Rhode Island general laws section 27-20-6.2. The commissioner may waive one
16 or more of the requirements of the regulations adopted under section 2715 of the Affordable Care
17 Act for good cause shown. The summary must contain at least the following information:
18 (1) Uniform definitions of standard insurance and medical terms.
19 (2) A description of coverage and cost sharing for each category of essential benefits and
20 other benefits.
21 (3) Exceptions, reductions and limitations in coverage.
22 (4) Renewability and continuation of coverage provisions.
23 (5) A "coverage facts label" that illustrates coverage under common benefits scenarios.
24 (6) A statement of whether the policy, contract or plan provides the minimum coverage
25 required of a qualified health plan.
26 (7) A statement that the outline is a summary and that the actual policy language should
27 be consulted; and
28 (8) A contact number for the consumer to call with additional questions and the web
29 address of where the actual language of the policy, contract or plan can be found.
30 (b) The provisions of this section shall apply to grandfathered health plans.
31 **27-20-6.2. Filing of policy forms. –** A nonprofit medical service corporation shall file all
32 policy forms and rates used by it in the state with the commissioner, including the forms of any
33 rider, endorsement, application blank, and other matter generally used or incorporated by
34 reference in its policies or contracts of insurance. No such rate shall be used unless first approved

by the commissioner. No such form shall be used if disapproved by the commissioner under this section, or if the commissioner's approval has been withdrawn after notice and an opportunity to be heard, or until the expiration of sixty (60) days following the filing of the form. A nonprofit medical service corporation shall comply with its filed and approved rates and forms. If the commissioner finds from an examination of any form that it is contrary to the public interest, or the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the corporation in writing. Each form shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance with applicable laws and that the benefits are reasonable in relation to the premium to be charged.

27-20-62. Prohibition on rescission of coverage. – (a)(1) Coverage under a health benefit plan subject to the jurisdiction of the commissioner under this chapter with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, shall not be subject to rescission after the individual is covered under the plan, unless:

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

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

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

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

(d) This section applies to grandfathered health plans.

27-20-63. Annual and lifetime limits. – (a) Annual limits.

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

(A) For a plan or policy year beginning after September 22, 2010, but before September 23, 2011 – seven hundred fifty thousand dollars ($750,000);

1 (B) For a plan or policy year beginning after September 22, 2011, but before September
2 23, 2012 – one million two hundred fifty thousand dollars ($1,250,000); and
3 (C) For a plan or policy year beginning after September 22, 2012, but before January 1,
4 2014 – two million dollars ($2,000,000).
5 (2) For plan or policy years beginning on or after January 1, 2014, a health insurance
6 carrier and health benefit plan shall not establish any annual limit on the dollar amount of
7 essential health benefits for any individual, except:
8 (A) A health flexible spending arrangement, as defined in section 106(c)(2)(i) of the
9 Internal Revenue Code, a medical savings account, as defined in section 220 of the Internal
10 Revenue Code, and a health savings account, as defined in section 223 of the Internal Revenue
11 Code are not subject to the requirements of subdivisions (1) and (2) of this subsection.
12 (B) The provisions of this subsection shall not prevent a health insurance carrier from
13 placing annual dollar limits for any individual on specific covered benefits that are not essential
14 health benefits to the extent that such limits are otherwise permitted under applicable federal law
15 or the laws and regulations of this state.
16 (3) In determining whether an individual has received benefits that meet or exceed the
17 allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier shall
18 take into account only essential health benefits as administratively established by the
19 commissioner.
20 (b) Lifetime limits.
21 (1) A health insurance carrier and health benefit plan offering group or individual health
22 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
23 benefits, as designated pursuant to a state determination and in accordance with federal laws and
24 regulations, for any individual.
25 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
26 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
27 benefits that are not essential health benefits, as designated pursuant to a state determination and
28 in accordance with federal laws and regulations.
29 (c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this
30 subsection, this subsection applies to any individual:
31 (A) Whose coverage or benefits under a health plan ended by reason of reaching a
32 lifetime limit on the dollar value of all benefits for the individual; and
33 (B) Who, due to the provisions of this section, becomes eligible, or is required to become
34 eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the

1 health benefit plan:

2 (i) For group health insurance coverage, on the first day of the first plan year beginning

3 on or after September 23, 2010; or

4 (ii) For individual health insurance coverage, on the first day of the first policy year

5 beginning on or after September 23, 2010.

6 (2) For individual health insurance coverage, an individual is not entitled to reinstatement

7 under the health benefit plan under this subsection if the individual reached his or her lifetime

8 limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection

9 applies to a family member who reached his or her lifetime limit in a family plan and other family

10 members remain covered under the plan.

11 (3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to

12 become eligible for benefits under the health benefit plan, the health carrier shall provide the

13 individual written notice that:

14 (i) The lifetime limit on the dollar value of all benefits no longer applies; and

15 (ii) The individual, if still covered under the plan, is again eligible to receive benefits

16 under the plan.

17 (B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for,

18 but not enrolled in any benefit package under the plan, the health benefit plan shall provide an

19 opportunity for the individual to enroll in the plan for a period of at least thirty (30) days.

20 (C) The notices and enrollment opportunity under this subdivision shall be provided

21 beginning not later than:

22 (i) For group health insurance coverage, the first day of the first plan year beginning on

23 or after September 23, 2010; or

24 (ii) For individual health insurance coverage, the first day of the first policy year

25 beginning on or after September 23, 2010.

26 (iii) The notices required under this subsection shall be provided:

27 (I) For group health insurance coverage, to an employee on behalf of the employee's

28 dependent; or

29 (II) For individual health insurance coverage, to the primary subscriber on behalf of the

30 primary subscriber's dependent.

31 (D) For group health insurance coverage, the notices may be included with other

32 enrollment materials that a health plan distributes to employees, provided the statement is

33 prominent. For group health insurance coverage, if a notice satisfying the requirements of this

34 subsection is provided to an individual, a health insurance carrier's requirement to provide the

1 notice with respect to that individual is satisfied.

2 (E) For any individual who enrolls in a health plan in accordance with subdivision (2) of

3 this subsection, coverage under the plan shall take effect not later than:

4 (i) For group health insurance coverage, the first day of the first plan year beginning on

5 or after September 23, 2010; or

6 (ii) For individual health insurance coverage, the first day of the first policy year

7 beginning on or after September 23, 2010.

8 (d)(1) An individual enrolling in a health plan for group health insurance coverage in

9 accordance with subsection (c) above shall be treated as if the individual were a special enrollee,

10 as provided under regulations interpreting the Health Insurance Portability and Accountability

11 Act ("HIPAA") portability provisions issued pursuant to Section 2714 of the Affordable Care

12 Act.

13 (2) An individual enrolling in accordance with subsection (c) above:

14 (A) shall be offered all of the benefit packages available to similarly situated individuals

15 who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value

16 of all benefits; and

17 (B) shall not be required to pay more for coverage than similarly situated individuals who

18 did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

19 (3) For purposes of subsection B(1), any difference in benefits or cost-sharing constitutes

20 a different benefit package.

21 (e)(1) Except as provided in subdivision (2) of this subsection, this section applies to any

22 health insurance carrier providing coverage under an individual or group health plan.

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

24 (B) The prohibition and limits on annual limits apply to grandfathered health plans

25 providing group health insurance coverage, but the prohibition and limits on annual limits do not

26 apply to grandfathered health plans providing individual health insurance coverage.

27 **27-20-64. Coverage for preventive items and services. –** (a) Every health insurance

28 carrier providing coverage under an individual or group health plan shall provide coverage for all

29 of the following items and services, and shall not impose any cost-sharing requirements, such as a

30 copayment, coinsurance or deductible, with respect to the following items and services:

31 (1) Except as otherwise provided in subsection (b) of this section, and except as may

32 otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-

33 based items or services that have in effect a rating of A or B in the recommendations of the

34 United States preventive services task force as of September 23, 201 and as may subsequently be

1 amended.

2 (2) Immunizations for routine use in children, adolescents and adults that have in effect a
3 recommendation from the Advisory Committee on Immunization Practices of the Centers for
4 Disease Control and Prevention with respect to the individual involved. For purposes of this
5 subdivision, a recommendation from the Advisory Committee on Immunization Practices of the
6 Centers for Disease Control and Prevention is considered in effect after it has been adopted by the
7 Director of the Centers for Disease Control and Prevention, and a recommendation is considered
8 to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease
9 Control and Prevention.

10 (3) With respect to infants, children and adolescents, evidence-informed preventive care,
11 and screenings provided for in comprehensive guidelines supported by the Health Resources and
12 Services Administration.

13 (4) With respect to women, to the extent not described in subdivision (1) of this
14 subsection, evidence-informed preventive care and screenings provided for in comprehensive
15 coverage guidelines supported by the Health Resources and Services Administration.

16 (b)(1) A health insurance carrier is not required to provide coverage for any items or
17 services specified in any recommendation or guideline described in subsection (a) of this section
18 after the recommendation or guideline is no longer described in subsection (a) of this section. The
19 provisions of this subdivision shall not affect the obligation of the health insurance carrier to
20 provide notice to a covered person before any material modification of coverage becomes
21 effective, in accordance with other requirements of state and federal law, including section
22 2715(d)(4) of the Public Health Services Act.

23 (2) A health insurance carrier shall at least annually at the beginning of each new plan
24 year or policy year, whichever is applicable, revise the preventive services covered under its
25 health benefit plans pursuant to this section consistent with the recommendations of the United
26 States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the
27 Centers for Disease Control and Prevention and the guidelines with respect to infants, children,
28 adolescents and women evidence-based preventive care and screenings by the Health Resources
29 and Services Administration in effect at the time.

30 (c)(1) A health insurance carrier may impose cost-sharing requirements with respect to an
31 office visit if an item or service described in subsection (a) of this section is billed separately or is
32 tracked as individual encounter data separately from the office visit.

33 (2) A health insurance carrier shall not impose cost-sharing requirements with respect to
34 an office visit if an item or service described in subsection (a) of this section is not billed

1 separately or is not tracked as individual encounter data separately from the office visit and the
2 primary purpose of the office visit is the delivery of the item or service described in subsection
3 (a) of this section.
4 (3) A health insurance carrier may impose cost-sharing requirements with respect to an
5 office visit if an item or service described in subsection (a) of this section is not billed separately
6 or is not tracked as individual encounter data separately from the office visit and the primary
7 purpose of the office visit is not the delivery of the item or service.
8 (d)(1) Nothing in this section requires a health insurance carrier that has a network of
9 providers to providing coverage for items and services described in subsection (a) of this section
10 that are delivered by an out-of-network provider.
11 (2) Nothing in subsection (a) of this section precludes a health insurance carrier that has a
12 network of providers from imposing cost-sharing requirements for items or services described in
13 subsection (a) of this section that are delivered by an out-of-network provider.
14 (e) Nothing prevents a health insurance carrier from using reasonable medical
15 management techniques to determine the frequency, method, treatment or setting for an item or
16 service described in subsection (a) of this section to the extent not specified in the
17 recommendation or guideline.
18 (f) Nothing in this section prohibits a health insurance carrier from providing coverage
19 for items and services in addition to those recommended by the United States Preventive Services
20 Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease
21 Control and Prevention, or provided by guidelines supported by the Health Resources and
22 Services Administration, or from denying coverage for items and services that are not
23 recommended by that task force or that advisory committee, or under those guidelines. A health
24 insurance carrier may impose cost-sharing requirements for a treatment not described in
25 subsection (a) of this section even if the treatment results from an item or service described in
26 subsection (a) of this section.
27 (g) This section shall not apply to grandfathered health plans.
28 **27-20-65. Coverage for individuals participating in approved clinical trials. –** (a) As
29 used in this section,
30 (1) “Approved clinical trial” means a phase I, phase II, phase III or phase IV clinical trial
31 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
32 threatening disease or condition and is described in any of the following:
33 (A) The study or investigation is approved or funded, which may include funding through
34 in-kind contributions, by one or more of the following:

1 (i) The National Institutes of Health;

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

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

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

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

6 or the Department of Defense or the Department of Veteran Affairs;

7 (vi) A qualified non-governmental research entity identified in the guidelines issued by

8 the National Institutes of Health for center support grants; or

9 (vii) A study or investigation conducted by the Department of Veteran Affairs, the

10 Department of Defense, or the Department of Energy, if the study or investigation has been

11 reviewed and approved through a system of peer review that the Secretary of U.S. Department of

12 Health and Human Services determines:

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

14 National Institutes of Health; and

15 (II) Assures unbiased review of the highest scientific standards by qualified individuals

16 who have no interest in the outcome of the review.

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

18 reviewed by the Food and Drug Administration; or

19 (C) The study or investigation is a drug trial that is exempt from having such an

20 investigational new drug application.

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

22 (3) "Participating provider" means a health care provider that, under a contract with the

23 health carrier or with its contractor or subcontractor, has agreed to provide health care services to

24 covered persons with an expectation of receiving payment, other than coinsurance, copayments or

25 deductibles, directly or indirectly from the health carrier.

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

27 conditions:

28 (A) The individual is eligible to participate in an approved clinical trial according to the

29 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;

30 and

31 (B)(i) The referring health care professional is a participating provider and has concluded

32 that the individual's participation in such trial would be appropriate based on the individual

33 meeting the conditions described in subdivision (A) of this subdivision (3); or

34 (ii) The participant or beneficiary provides medical and scientific information

1 establishing the individual's participation in such trial would be appropriate based on the
2 individual meeting the conditions described in subdivision (A) of this subdivision (3).
3 (5) "Life-threatening condition" means any disease or condition from which the
4 likelihood of death is probable unless the course of the disease or condition is interrupted.
5 (b)(1) If a health insurance carrier offering group or individual health insurance coverage
6 provides coverage to a qualified individual, the health carrier:
7 (A) Shall not deny the individual participation in an approved clinical trial.
8 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose
9 additional conditions on the coverage of routine patient costs for items and services furnished in
10 connection with participation in the clinical approved trial; and
11 (C) Shall not discriminate against the individual on the basis of the individual's
12 participation in the clinical trial.
13 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all
14 items and services consistent with the coverage typically covered for a qualified individual who is
15 not enrolled in an approved clinical trial.
16 (B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not
17 include:
18 (i) The investigational item, device or service itself;
19 (ii) Items and services that are provided solely to satisfy data collection and analysis
20 needs and that are not used in the direct clinical management of the patient; or
21 (iii) A service that is clearly inconsistent with widely accepted and established standards
22 of care for a particular diagnosis.
23 (3) If one or more participating providers is participating in a clinical trial, nothing in
24 subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring
25 that a qualified individual participate in the trial through such a participating provider if the
26 provider will accept the individual as a participant in the trial.
27 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection
28 shall apply to a qualified individual participating in an approved clinical trial that is conducted
29 outside this state.
30 (5) This section shall not be construed to require a nonprofit medical service corporation
31 offering group or individual health insurance coverage to provide benefits for routine patient care
32 services provided outside of the coverage's health care provider network unless out-of-network
33 benefits are otherwise provided under the coverage.
34 (6) Nothing in this section shall be construed to limit a health insurance carrier's

coverage with respect to clinical trials.

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

(d) This section shall not apply to grandfathered health plans.

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

27-20-66. Medical loss ratio rebates. – (a) A nonprofit medical service corporation offering group or individual health insurance coverage, including a grandfathered health plan, shall pay medical loss ratio rebates as provided for in Section 2718(b)(1)(A) of the Affordable Care Act, in the manner and as required by federal laws and regulations.

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

27-20-67. Emergency services -- (a) As used in this section:

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

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

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

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

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

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

1 (c) A nonprofit medical service corporation shall provide coverage for emergency
2 services in the following manner:
3 (1) Without the need for any prior authorization determination, even if the emergency
4 services are provided on an out-of-network basis;
5 (2) Without regard to whether the health care provider furnishing the emergency services
6 is a participating network provider with respect to the services;
7 (3) If the emergency services are provided out of network, without imposing any
8 administrative requirement or limitation on coverage that is more restrictive than the requirements
9 or limitations that apply to emergency services received from in-network providers;
10 (4) If the emergency services are provided out of network, by complying with the cost-
11 sharing requirements of subsection (d) of this section; and
12 (5) Without regard to any other term or condition of the coverage, other than:
13 (A) The exclusion of or coordination of benefits;
14 (B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title
15 XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or
16 (C) Applicable cost-sharing.
17 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
18 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
19 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
20 the services were provided in-network. However, a participant or beneficiary may be required to
21 pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network
22 provider charges over the amount the plan or health insurance carrier is required to pay under
23 subdivision (1) of this subsection. A group health plan or health insurance carrier complies with
24 the requirements of this subsection if it provides benefits with respect to an emergency service in
25 an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
26 this subdivision (1)(which are adjusted for in-network cost-sharing requirements).
27 (A) The amount negotiated with in-network providers for the emergency service
28 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
29 participant or beneficiary. If there is more than one amount negotiated with in-network providers
30 for the emergency service, the amount described under this subdivision (A) is the median of these
31 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
32 participant or beneficiary. In determining the median described in the preceding sentence, the
33 amount negotiated with each in-network provider is treated as a separate amount (even if the
34 same amount is paid to more than one provider). If there is no per-service amount negotiated with

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

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

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

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

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

(f) This section shall not apply to grandfathered health plans.

27-20-68. Internal and external appeal of adverse benefit determinations. -- (a) The commissioner shall adopt regulations to implement standards and procedures with respect to internal claims and appeals of adverse benefit determinations, and with respect to external appeals of adverse benefit determinations.

(b) The regulations adopted by the commissioner shall apply to those adverse benefit determinations within the jurisdiction of the commissioner.

SECTION 8. Sections 27-41-2 and 27-41-61 of the General laws in Chapter 27-41 entitled "Health Maintenance Organizations" are hereby amended to read as follows:

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

(a) Adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan or to

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

(b) "Affordable Care Act" means the Patient Protection and Affordable Care act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

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

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

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

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

~~(d)~~(g) "Employer" means any person, partnership, association, trust, estate, or corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy, receiver, or trustee of a receiver, or the legal representative of a deceased person, including the state of Rhode Island and each city and town in the state, which has in its employ one or more individuals during any calendar year. For the purposes of this section, the term "employer" refers only to an employer with persons employed within the state of Rhode Island.

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

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

(j) “Grandfathered health plan” means any group health plan or health insurance coverage

1 subject to 42 USC section 18011.

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

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

7 (m) “Health benefits” or “covered benefits” means medical, surgical, hospital,
8 prescription drug, and such other benefits, whether self-funded, or delivered through the purchase
9 of insurance or otherwise.

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

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

17 (p) "Health care provider" or "provider" means a health care professional or a health care
18 facility.

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

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

26 ~~(h)~~(s) "Health maintenance organization" means a single public or private organization
27 which:

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

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

(3) Provides physicians' services primarily:

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

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

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

(4) Provides the services of licensed midwives primarily:

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

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

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

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

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

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

~~(l)~~(x) "Physician" includes podiatrist as defined in chapter 29 of title 5.

~~(m)~~(y) "Private organization" means a legal corporation with a policy making and governing body.

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

~~(o)~~(aa) "Public organization" means an instrumentality of government.

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

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

~~(q)~~(dd) "Total adjusted capital" means the sum of:

1 (1) A health maintenance organization's statutory capital and surplus (i.e. net worth) as
2 determined in accordance with the statutory accounting applicable to the annual financial
3 statements required to be filed under section 27-41-9; and
4 (2) Any other items, if any, that the RBC instructions provide.
5 (r)(ee) "Uncovered expenditures" means the costs of health care services that are covered
6 by a health maintenance organization, but that are not guaranteed, insured, or assumed by a
7 person or organization other than the health maintenance organization. Expenditures to a provider
8 that agrees not to bill enrollees under any circumstances are excluded from this definition.
9 **27-41-61. Termination of children's benefits. – Eligibility for children's benefits -**
10 (a)(1) Every individual health insurance contract, plan, or policy delivered, issued for delivery, or
11 renewed in this state which provides medical health benefits coverage for dependent children that
12 includes coverage for physician services in a physician's office, and every policy which provides
13 major medical or similar comprehensive type coverage, dependents, except for supplemental
14 policies which only provide coverage for specified diseases and other supplemental policies, shall
15 provide make coverage available of an unmarried child under the age of nineteen (19) years, an
16 unmarried child who is a student under the age of twenty-five (25) years and who is financially
17 dependent upon the parent and an unmarried child of any age who is financially dependent upon
18 the parent and medically determined to have a physical or mental impairment which can be
19 expected to result in death or which has lasted or can be expected to last for a continuous period
20 of not less than twelve (12) months. for children until attainment of twenty-six (26) years of age.
21 Such contract, plan or policy shall also include a provision that policyholders shall receive no less
22 than thirty (30) days notice from the health maintenance organization that a child is about to lose
23 his or her coverage as a result of reaching the maximum age for a dependent child and that the
24 child will only continue to be covered upon documentation being provided of current full or part-
25 time enrollment in a post secondary educational institution, or that the child may purchase a
26 conversion policy if he or she is not an eligible student.
27 (b) Nothing in this section prohibits a nonprofit health maintenance organization from
28 requiring a policyholder to annually provide proof of a child's current full or part-time enrollment
29 in a post-secondary educational institution in order to maintain the child's coverage. Provided,
30 nothing in this section requires coverage inconsistent with the membership criteria in effect under
31 the policyholder's health benefits coverage.
32 (2) With respect to a child who has not attained twenty-six (26) years of age, a health
33 maintenance organization shall not define "dependent" for purposes of eligibility for dependent
34 coverage of children other than the terms of a relationship between a child and the plan

1 participant, and, in the individual market, primary subscriber.

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

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

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

15 (b)(1) This subsection applies to any child:

16 (A) Whose coverage ended, or who was denied coverage, or was not eligible for group
17 health insurance coverage or individual health insurance coverage under a health benefit plan
18 because, under the terms of coverage, the availability of dependent coverage of a child ended
19 before the attainment of twenty-six (26) years of age; and

20 (B) Who becomes eligible, or is required to become eligible, for coverage on the first day
21 of the first plan year and, in the individual market, the first day of the first policy year, beginning
22 on or after September 23, 2010 by reason of the provisions of this section.

23 (2)(A) If group health insurance coverage or individual health insurance coverage, in
24 which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in
25 which the child's coverage ended or did not begin for the reasons described in subdivision (1) of
26 this subsection, and if the health insurance carrier is subject to the requirements of this section the
27 health insurance carrier shall give the child an opportunity to enroll that continues for at least 60
28 days, including the written notice of the opportunity to enroll as described subdivision (3) of this
29 subsection.

30 (B) The health insurance carrier shall provide the opportunity to enroll, including the
31 written notice beginning not later than the first day of the first plan year and in the individual
32 market the first day of the first policy year, beginning on or after September 23, 2010.

33 (3)(A) The written notice of opportunity to enroll shall include a statement that children
34 whose coverage ended, or who were denied coverage, or were not eligible for coverage, because

1 the availability of dependent coverage of children ended before the attainment of twenty-six (26)
2 years of age are eligible to enroll in the coverage.
3 (B)(i) The notice may be provided to an employee on behalf of the employee's child and,
4 in the individual market, to the primary subscriber on behalf of the primary subscriber's child.
5 (ii) For group health insurance coverage:
6 (I) The notice may be included with other enrollment materials that the health carrier
7 distributes to employees, provided the statement is prominent; and
8 (II) If a notice satisfying the requirements of this subdivision is provided to an employee
9 whose child is entitled to an enrollment opportunity under subsection (c) of this section, the
10 obligation to provide the notice of enrollment opportunity under subdivision (B) of this
11 subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.
12 (C) The written notice shall be provided beginning not later than the first day of the first
13 plan year and in the individual market the first day of the first policy year, beginning on or after
14 September 23, 2010.
15 (4) For an individual who enrolls under this subsection, the coverage shall take effect not
16 later than the first day of the first plan year and, in the individual market, the first day of the first
17 policy year, beginning on or after September 23, 2010.
18 (c)(1) A child enrolling in group health insurance coverage pursuant to subsection (b) of
19 this section shall be treated as if the child were a special enrollee, as provided under regulations
20 interpreting the HIPAA portability provisions issued pursuant to section 2714 of the Affordable
21 Care.
22 (2)(A) The child and, if the child would not be a participant once enrolled, the participant
23 through whom the child is otherwise eligible for coverage under the plan, shall be offered all the
24 benefit packages available to similarly situated individuals who did not lose coverage by reason
25 of cessation of dependent status.
26 (B) For purposes of this subdivision (2), any difference in benefits or cost-sharing
27 requirements constitutes a different benefit package.
28 (3) The child shall not be required to pay more for coverage than similarly situated
29 individuals who did not lose coverage by reason of cessation of dependent status.
30 (d)(1) For plan years beginning before January 1, 2014, a group health plan providing
31 group health insurance coverage that is a grandfathered health plan and makes available
32 dependent coverage of children may exclude an adult child who has not attained twenty-six (26)
33 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-
34 sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code,

other than the group health plan of a parent.

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

(3) The provisions of this section apply to policy years in the individual market on and after September 23, 2010.

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

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

27-41-29.1. Uniform explanation of benefits and coverage. -- (a) A health maintenance organization shall provide a uniform summary of benefits and coverage explanation and standardized definitions to policyholders and others required by, and at the times required by, the federal regulations adopted under section 2715 of the Affordable Care Act. A summary required by this section shall be filed with the commissioner for approval under Rhode Island general laws section 27-41-29.2. The requirements of this section shall be in addition to any other requirements imposed as conditions of approval under Rhode Island general laws sections 27-41-29.2. The commissioner may waive one or more of the requirements of the regulations adopted under section 2715 of the Affordable Care Act for good cause shown. The summary must contain at least the following information:

(1) Uniform definitions of insurance and medical terms.

(2) A description of coverage and cost-sharing for each category of essential benefits and other benefits.

(3) Exceptions, reductions and limitations in coverage.

(4) Renewability and continuation of coverage provisions.

(5) A "coverage facts label" that illustrates coverage under common benefits scenarios.

(6) A statement of whether the policy, contract or plan provides the minimum coverage required of a qualified health plan.

(7) A statement that the outline is a summary and that the actual policy language should be consulted; and

(8) A contact number for the consumer to call with additional questions and the web address of where the actual language of the policy, contract or plan can be found.

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

2 **27-41-29.2. Filing of policy forms. --** A health maintenance organization shall file all
3 policy forms and rates used by it in the state with the commissioner, including the forms of any
4 rider, endorsement, application blank, and other matter generally used or incorporated by
5 reference in its policies or contracts of insurance. No such rate shall be used unless first approved
6 by the commissioner. No such form shall be used if disapproved by the commissioner under this
7 section, or if the commissioner's approval has been withdrawn after notice and an opportunity to
8 be heard, or until the expiration of sixty (60) days following the filing of the form. A health
9 maintenance organization shall comply with its filed and approved rates and forms. If the
10 commissioner finds from an examination of any form that it is contrary to the public interest or
11 the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and
12 shall notify the corporation in writing. Each form shall include a certification by a qualified
13 actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance
14 with applicable laws and that the benefits are reasonable in relation to the premium to be charged.

15 **27-41-75. Prohibition on rescission of coverage. --** (a)(1) Coverage under a health plan
16 subject to the jurisdiction of the commissioner under this chapter with respect to an individual,
17 including a group to which the individual belongs or family coverage in which the individual is
18 included, shall not be rescinded after the individual is covered under the plan, unless:

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

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

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

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

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

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

1 **27-41-76. Prohibition on annual and lifetime limits. --** (a) Annual limits.

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

6 (A) For a plan or policy year beginning after September 22, 2010, but before September
7 23, 2011 – seven hundred fifty thousand dollars ($750,000);

8 (B) For a plan or policy year beginning after September 22, 2011, but before September
9 23, 2012 – one million two hundred fifty thousand dollars ($1,250,000); and

10 (C) For a plan or policy year beginning after September 22, 2012, but before January 1,
11 2014 – two million dollars ($2,000,000).

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

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

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

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

27 (b) Lifetime limits.

28 (1) A health insurance carrier and health benefit plan offering group or individual health
29 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
30 benefits, as designated pursuant to a state determination and in accordance with federal laws and
31 regulations, for any individual.

32 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
33 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
34 benefits that are not essential health benefits, as designated pursuant to a state determination and

in accordance with federal laws and regulations.

(c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this subsection, this subsection applies to any individual:

(A) Whose coverage or benefits under a health plan ended by reason of reaching a lifetime limit on the dollar value of all benefits for the individual; and

(B) Who, due to the provisions of this section, becomes eligible, or is required to become eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the health benefit plan:

(i) For group health insurance coverage, on the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, on the first day of the first policy year beginning on or after September 23, 2010.

(2) For individual health insurance coverage, an individual is not entitled to reinstatement under the health benefit plan under this subsection if the individual reached his or her lifetime limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection applies to a family member who reached his or her lifetime limit in a family plan and other family members remain covered under the plan.

(3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to become eligible for benefits under the health benefit plan, the health maintenance organization shall provide the individual written notice that:

(i) The lifetime limit on the dollar value of all benefits no longer applies; and

(ii) The individual, if still covered under the plan, is again eligible to receive benefits under the plan.

(B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for, but not enrolled in any benefit package under the plan, the health maintenance organization shall provide an opportunity for the individual to enroll in the plan for a period of at least thirty (30) days.

(C) The notices and enrollment opportunity under this subdivision shall be provided beginning not later than:

(i) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

(iii) The notices required under this subsection shall be provided:

1 (I) For group health insurance coverage, to an employee on behalf of the employee's
2 dependent; or
3 (II) For individual health insurance coverage, to the primary subscriber on behalf of the
4 primary subscriber's dependent.
5 (D) For group health insurance coverage, the notices may be included with other
6 enrollment materials that a health maintenance organization distributes to subscribers, provided
7 the statement is prominent. For group health insurance coverage, if a notice satisfying the
8 requirements of this subsection is provided to an individual, a health maintenance organization's
9 requirement to provide the notice with respect to that individual is satisfied.
10 (E) For any individual who enrolls in a health maintenance organization in accordance
11 with subdivision (2) of this subsection, coverage under the plan shall take effect not later than:
12 (i) For group health insurance coverage, the first day of the first plan year beginning on
13 or after September 23, 2010; or
14 (ii) For individual health insurance coverage, the first day of the first policy year
15 beginning on or after September 23, 2010.
16 (d)(1) An individual enrolling in a health maintenance organization for group health
17 insurance coverage in accordance with subsection (c) above shall be treated as if the individual
18 were a special enrollee in the plan, as provided under regulations interpreting the HIPAA
19 portability provisions issued pursuant to Section 2714 of the Affordable Care Act.
20 (2) An individual enrolling in accordance with subsection (c) of this subsection:
21 (A) shall be offered all of the benefit packages available to similarly situated individuals
22 who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value
23 of all benefits; and
24 (B) shall not be required to pay more for coverage than similarly situated individuals who
25 did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.
26 (3) For purposes of subsection B(1), any difference in benefits or cost-sharing constitutes
27 a different benefit package.
28 (e)(1) The provisions of this section relating to lifetime limits apply to any health
29 maintenance organization or health insurance carrier providing coverage under an individual or
30 group health plan, including grandfathered health plans.
31 (2) The provisions of this section relating to annual limits apply to any health
32 maintenance organization or health insurance carrier providing coverage under a group health
33 plan, including grandfathered health plans, but the prohibition and limits on annual limits do not
34 apply to grandfathered health plans providing individual health insurance coverage.

27-41-77. Coverage for Preventive Items and Services. -- (a) Every health maintenance organization providing coverage under an individual or group health plan shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(1) Except as otherwise provided in subsection (b) of this section, and except as may otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010 and as may subsequently be amended.

(2) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

(3) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(4) With respect to women, to the extent not described in subdivision (1) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive coverage guidelines supported by the Health Resources and Services Administration.

(b)(1) A health maintenance organization is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection (a) of this section after the recommendation or guideline is no longer described in subsection (a) of this section. The provisions of this subdivision shall not affect the obligation of the health maintenance organization to provide notice to a covered person before any material modification of coverage becomes effective, in accordance with including section 2715(d)(4) of the Public Health Services Act.

(2) A health maintenance organization shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization

1 Practices of the Centers for Disease Control and Prevention and the guidelines with respect to
2 infants, children, adolescents and women evidence-based preventive care and screenings by the
3 Health Resources and Services Administration in effect at the time.
4 (c)(1) A health maintenance organization insurance carrier may impose cost-sharing
5 requirements with respect to an office visit if an item or service described in subsection (a) of this
6 section is billed separately or is tracked as individual encounter data separately from the office
7 visit.
8 (2) A health maintenance organization shall not impose cost-sharing requirements with
9 respect to an office visit if an item or service described in subsection (a) of this section is not
10 billed separately or is not tracked as individual encounter data separately from the office visit and
11 the primary purpose of the office visit is the delivery of the item or service described in
12 subsection (a) of this section.
13 (3) A health maintenance organization may impose cost-sharing requirements with
14 respect to an office visit if an item or service described in subsection (a) of this section is not
15 billed separately or is not tracked as individual encounter data separately from the office visit and
16 the primary purpose of the office visit is not the delivery of the item or service.
17 (d)(1) Nothing in this section requires a health maintenance organization that has a
18 network of providers to providing coverage for items and services described in subsection (a) of
19 this section that are delivered by an out-of-network provider.
20 (2) Nothing in subsection (a) of this section precludes a health maintenance organization
21 insurance carrier that has a network of providers from imposing cost-sharing requirements for
22 items or services described in subsection (a) of this section that are delivered by an out-of-
23 network provider.
24 (e) Nothing prevents a health maintenance organization from using reasonable medical
25 management techniques to determine the frequency, method, treatment or setting for an item or
26 service described in subsection (a) of this section to the extent not specified in the
27 recommendation or guideline.
28 (f) Nothing in this section prohibits a health maintenance organization from providing
29 coverage for items and services in addition to those recommended by the United States
30 Preventive Services Task Force or the Advisory Committee on Immunization Practices of the
31 Centers for Disease Control and Prevention, or provided by guidelines supported by the Health
32 Resources and Services Administration, or from denying coverage for items and services that are
33 not recommended by that task force or that advisory committee, or under those guidelines. A
34 health maintenance organization may impose cost-sharing requirements for a treatment not

1 described in subsection (a) of this section even if the treatment results from an item or service

2 described in subsection (a) of this section.

3 (g) This section shall not apply to grandfathered health plans.

4 **27-41-78. Coverage for individual participating in approved clinical trials. --** (a) As

5 used in this section.

6 (1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial

7 that is conducted in relation to the prevention, detection or treatment of cancer or a life-

8 threatening disease or condition and is described in any of the following:

9 (A) The study or investigation is approved or funded, which may include funding through

10 in-kind contributions, by one or more of the following:

11 (i) The National Institutes of Health;

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

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

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

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

16 or the Department of Defense or the Department of Veteran Affairs;

17 (vi) A qualified non-governmental research entity identified in the guidelines issued by

18 the National Institutes of Health for center support grants; or

19 (vii) A study or investigation conducted by the Department of Veteran Affairs, the

20 Department of Defense, or the Department of Energy, if the study or investigation has been

21 reviewed and approved through a system of peer review that the Secretary of U.S. Department of

22 Health and Human Services determines:

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

24 National Institutes of Health; and

25 (II) Assures unbiased review of the highest scientific standards by qualified individuals

26 who have no interest in the outcome of the review.

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

28 reviewed by the Food and Drug Administration; or

29 (C) The study or investigation is a drug trial that is exempt from having such an

30 investigational new drug application.

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

32 (3) "Participating provider" means a health care provider that, under a contract with the

33 health carrier or with its contractor or subcontractor, has agreed to provide health care services to

34 covered persons with an expectation of receiving payment, other than coinsurance, copayments or

1 deductibles, directly or indirectly from the health carrier.

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

3 conditions:

4 (A) The individual is eligible to participate in an approved clinical trial according to the

5 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;

6 and

7 (B)(i) The referring health care professional is a participating provider and has concluded

8 that the individual's participation in such trial would be appropriate based on the individual

9 meeting the conditions described in subdivision (A) of this subdivision (3); or

10 (ii) The participant or beneficiary provides medical and scientific information

11 establishing the individual's participation in such trial would be appropriate based on the

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

13 (5) "Life-threatening condition" means any disease or condition from which the

14 likelihood of death is probable unless the course of the disease or condition is interrupted.

15 (b)(1) If a health maintenance organization offering group or individual health insurance

16 coverage provides coverage to a qualified individual, it:

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

18 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose

19 additional conditions on the coverage of routine patient costs for items and services furnished in

20 connection with participation in the approved clinical trial; and

21 (C) Shall not discriminate against the individual on the basis of the individual's

22 participation in the approved clinical trial.

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

24 items and services consistent with the coverage typically covered for a qualified individual who is

25 not enrolled in an approved clinical trial.

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

27 include:

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

29 (ii) Items and services that are provided solely to satisfy data collection and analysis

30 needs and that are not used in the direct clinical management of the patient; or

31 (iii) A service that is clearly inconsistent with widely accepted and established standards

32 of care for a particular diagnosis.

33 (3) If one or more participating providers is participating in a clinical trial, nothing in

34 subdivision (1) of this subsection shall be construed as preventing a health maintenance

1 organization from requiring that a qualified individual participate in the trial through such a
2 participating provider if the provider will accept the individual as a participant in the trial.
3 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection
4 shall apply to a qualified individual participating in an approved clinical trial that is conducted
5 outside this state.
6 (5) This section shall not be construed to require a health maintenance organization
7 offering group or individual health insurance coverage to provide benefits for routine patient care
8 services provided outside of the coverage's health care provider network unless out-of-network
9 benefits are other provided under the coverage.
10 (6) Nothing in this section shall be construed to limit a health maintenance organization's
11 coverage with respect to clinical trials.
12 (c) The requirements of this section shall be in addition to the requirements of Rhode
13 Island general laws sections 27-41-41 through 27-41-41.3.
14 **27-41-79. Medical loss ratio rebates. --** (a) A health maintenance organization offering
15 group or individual health insurance coverage, including a grandfathered health plan, shall pay
16 medical loss ratio rebates as provided for in section 2718(b)(1)(A) of the Affordable Care Act, in
17 the manner and as required by federal laws and regulations.
18 (b) Health maintenance organizations required to report medical loss ratio and rebate
19 calculations and any other medical loss ratio or rebate information to the U.S. Department of
20 Health and Human Services shall concurrently file such information with the commissioner.
21 **27-41-80. Emergency services. --** (a) As used in this section:
22 (1)"Emergency medical condition" means a medical condition manifesting itself by acute
23 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
24 possesses an average knowledge of health and medicine, could reasonably expect the absence of
25 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
26 with respect to a pregnant woman her unborn child in serious jeopardy: (ii) Constituting a serious
27 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
28 part.
29 (2) "Emergency services" means, with respect to an emergency medical condition:
30 (A) A medical screening examination (as required under section 1867 of the Social
31 Security Act, 42 U.S.C. 1395 dd) that is within the capability of the emergency department of a
32 hospital, including ancillary services routinely available to the emergency department to evaluate
33 such emergency medical condition, and
34 (B) Such further medical examination and treatment, to the extent they are within the

1 capabilities of the staff and facilities available at the hospital, as are required under section 1867
2 of the Social Security Act (42 U.S.C. 1395 dd) to stabilize the patient.
3 (3) "Stabilize", with respect to an emergency medical condition has the meaning given in
4 section 1867(e)(3) of the Social Security Act (42 U.S.C.1395 dd(e)(3)).
5 (b) If a health maintenance organization offering group health insurance coverage
6 provides any benefits with respect to services in an emergency department of a hospital, it must
7 cover emergency services consistent with the rules of this section.
8 (c) A health maintenance organization shall provide coverage for emergency services in
9 the following manner:
10 (1) Without the need for any prior authorization determination, even if the emergency
11 services are provided on an out-of-network basis;
12 (2) Without regard to whether the health care provider furnishing the emergency services
13 is a participating network provider with respect to the services;
14 (3) If the emergency services are provided out of network, without imposing any
15 administrative requirement or limitation on coverage that is more restrictive than the requirements
16 or limitations that apply to emergency services received from in-network providers;
17 (4) If the emergency services are provided out of network, by complying with the cost-
18 sharing requirements of subsection (d) of this section; and
19 (5) Without regard to any other term or condition of the coverage, other than:
20 (A) The exclusion of or coordination of benefits;
21 (B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title
22 XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or
23 (C) Applicable cost sharing.
24 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
25 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
26 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
27 the services were provided in-network; provided, however, that a participant or beneficiary may
28 be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-
29 network provider charges over the amount the plan or health maintenance organization is required
30 to pay under subdivision (1) of this subsection. A health maintenance organization complies with
31 the requirements of this subsection if it provides benefits with respect to an emergency service in
32 an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
33 this subdivision (1)(which are adjusted for in-network cost-sharing requirements).
34 (A) The amount negotiated with in-network providers for the emergency service

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

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

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

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

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

(f) This section shall not apply to grandfathered health plans.

27-41-81. Internal and external appeal of adverse benefit determinations. -- (a) The commissioner shall adopt regulations to implement standards and procedures with respect to internal claims and appeals of adverse benefit determinations, and with respect to external appeals of adverse benefit determinations.

(b) The regulations adopted by the commissioner shall apply to those adverse benefit determinations within the jurisdiction of the commissioner.

1 SECTION 10. Section 42-14-5 of the General laws in Chapter 42-14 entitled
2 "Department of Business Regulation" is hereby amended to read as follows:
3 **42-14-5. Administrator of banking and insurance. --** (a) The director of business
4 regulation shall, in addition to his or her regular duties, act as administrator of banking and
5 insurance and shall administer the functions of the department relating to the regulation and
6 control of banking and insurance, foreign surety companies, sale of securities, building and loan
7 associations, and fraternal benefit and beneficiary societies.
8 (b) Wherever the words "banking administrator" or "insurance administrator" occur in
9 this chapter or any general law, public law, act, or resolution of the general assembly or
10 department regulation, they shall be construed to mean banking commissioner and insurance
11 commissioner except as delineated in subsection (d) below.
12 (c) "Health insurance" shall mean "health insurance coverage," as defined in 27-18.5-2
13 and 27-18.6-2, "health benefit plan," as defined in 27-50-3 and a "medical supplement policy," as
14 defined in 27-18.2-1or coverage similar to a Medicare supplement policy that is issued to an
15 employer to cover retirees, and dental coverage, including, but not limited to, coverage provided
16 by a nonprofit dental service plan as defined in subsection 27-20.1-1(3).
17 (d) Whenever the words "commissioner," "insurance commissioner", "Health insurance
18 commissioner" or "director" appear in Title 27or Title 42, those words shall be construed to mean
19 the health insurance commissioner established pursuant to 42-14.5-1with respect to all matters
20 relating to health insurance. The health insurance commissioner shall have sole and exclusive
21 jurisdiction over enforcement of those statutes with respect to all matters relating to health
22 insurance.
23 (e) In consultation with the commissioner of health, the health insurance commissioner
24 shall have concurrent jurisdiction to monitor, examine, and enforce the requirements of title 23
25 and regulations adopted thereunder relating to health insurance.
26 SECTION 11. Applicability. This act shall apply to health insurance policies, subscriber
27 contracts, and any other health benefit contract on and after July 1, 2012, except as otherwise
28 provided by the provisions of this act.
29 SECTION 12. This act shall take effect on passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N   A C T

RELATING TO INSURANCE -- HEALTH INSURANCE - CONSUMER PROTECTION

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1 This act would establish health insurance rules and standards in addition to, but not
2 inconsistent with, the health insurance standards established in the Patient Protection and
3 Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act
4 of 2010. These rules and standards would include, but are not limited to, prohibitions on
5 rescission of coverage, discrimination in coverage, and prohibitions on annual and lifetime limits
6 of coverage unless such limits meet set minimum amounts, as well as adding definitions to the
7 chapters covering health insurance.
8 This act would take effect upon passage.

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