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

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2019

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A N A C T

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

Introduced By: Senators Miller, McCaffrey, Ruggerio, Goodwin, and Goldin

Date Introduced: March 28, 2019

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

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

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

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

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

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

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

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

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

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

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Health Service Act, as amended by the ~~federal~~ Federal Affordable Care Act, provided they remain in effect, but if no longer in effect, the immediately prior version of such authorities shall control.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

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

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

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

(a) Annual limits.

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

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

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

~~(2) For plan or policy years beginning on or after January 1, 2014, a~~ 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)~~(1) A health flexible spending arrangement, as defined in Section 106(c)(2)(i) of the Federal Internal Revenue Code, a medical savings account, as defined in section 220 of the

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

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

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

(b) Lifetime limits.

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

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

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

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

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

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

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

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

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

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

SECTION 3. Sections 27-18.5-2, 27-18.5-3, 27-18.5-4, 27-18.5-5, 27-18.5-6 and 27-18.5-10 of the General Laws in Chapter 27-18.5 entitled "Individual Health Insurance Coverage" are hereby amended to read as follows:

27-18.5-2. Definitions.

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

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

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

~~(1)~~(3) "Bona fide association" means, with respect to health insurance coverage offered in this state, an association which:

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

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

insurance;

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

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

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

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

(vii) Has a constitution and bylaws; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Ambulatory patient services;

(ii) Emergency services;

(iii) Hospitalization;

(iv) Maternity and newborn care;

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

(vi) Prescription drugs;

(vii) Rehabilitative and habilitative services and devices;

(viii) Laboratory services;

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

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

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

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

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

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

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

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

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

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

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics;

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

(I) Short term limited duration insurance in accordance with regulations adopted by the commissioner;

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

(A) Limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

~~(9)~~(14) "Health status-related factor" means and includes, but is not limited to, any of the following factors:

(i) Health status;

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

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

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

(viii) Disability;

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

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

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

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

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

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

(18) "Preventive services" means those services described in 42 U.S.C. § 300gg-13 and implementing regulations and guidance, and shall be covered without any cost sharing for the enrollee when delivered by in-network providers, as those terms and obligations are therein described. If such authorities are no longer in effect, the immediately prior version of such authorities shall control. The commissioner shall determine which federally-recommended evidence-based services qualify as preventive care to the extent that federal recommendations change after January 1, 2019.

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

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

(1) Decline to offer the coverage to, or deny enrollment of, the individual; or

(2) Impose any preexisting condition exclusion with respect to the coverage.

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

~~(i) Are designed for, made generally available to, and actively market to, and enroll both eligible and other individuals by the carrier; and~~

~~(ii) Meet the requirements of subparagraph (A) or (B) of this paragraph as elected by the carrier:~~

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

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

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

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

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

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

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

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

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

(2) A carrier upon denying individual health insurance coverage in this state in accordance with this subsection may not offer that coverage in the individual market in this state

for a period of one hundred eighty (180) days after the date the coverage is denied or until the carrier has demonstrated to the ~~director~~ commissioner that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later.

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

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

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

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

(g) OHIC may pursue federal funding in support of the development of a high risk pool program, reinsurance program, a risk adjustment program, or any other program designed to maintain market stability for the individual market~~, as defined in § 27-18.5-2, contingent upon a thorough assessment of any financial obligation of the state related to the receipt of said federal funding being presented to, and approved by, the general assembly by passage of concurrent general assembly resolution~~. Such authority includes to work in collaboration with the health benefit exchange and any other state department to develop a waiver application under § 1332 of the Federal Affordable Care Act or successor programs. The components of ~~the high risk pool program~~ such programs, including, but not limited to, rating rules, eligibility requirements and

administrative processes, shall be designed in accordance with ~~§ 2745 of the Public Health Service Act (42 U.S.C. § 300gg-45) also known as the State High Risk Pool Funding Extension Act of 2006 and defined in regulations promulgated by the office of the health insurance commissioner on or before October 1, 2007~~ federal and state laws and regulations.

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

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

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

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

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

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

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

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

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

(2) The eligible individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage within two (2)

years after the effective date of this chapter or practice. After two (2) years, the carrier may not renew or discontinue under this subsection only if the eligible individual has failed to reimburse the carrier for the costs associated with the fraud or misrepresentation;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The ~~director~~ commissioner has the power to enforce the provisions of this chapter in accordance with § 42-14-16 and all other applicable laws.

27-18.5-6. Rules and regulations.

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

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

(a) A health insurance policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a resident of this state by a health insurance company licensed pursuant to this title and/or chapter shall not limit or exclude coverage for any individual by

imposing a preexisting condition exclusion on that individual.~~:~~

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

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

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

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

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

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

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

SECTION 4. Sections 27-18.6-2, 27-18.6-3, 27-18.6-5, 27-18.6-6, 27-18.6-7, 6-27-18.6-8 and 27-18.6-9 of the General Laws in Chapter 27-18.6 entitled "Large Group Health Insurance Coverage" are hereby amended to read as follows:

27-18.6-2. Definitions.

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

~~(1) "Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance~~

~~coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during the period and no premium shall be charged to the participant or beneficiary for any coverage during the period;~~

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

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

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

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

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

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

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

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

(vii) Has a constitution and bylaws; and

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

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

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

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

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

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

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

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

(7) "Dependent" means a spouse, child under the age twenty-six (26) years, or an

unmarried child of any age who is financially dependent upon the parent and is medically determined to have a physical or mental impairment which can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months;

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

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

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

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

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

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

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

(15)(i) "Health insurance coverage" means a policy, contract, certificate, or agreement offered by a health insurance carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health insurance coverage does include short-term and

catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition;

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

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

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

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

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

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

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

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

(A) Limited scope dental or vision benefits;

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

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

(iv) "Health insurance coverage" does not include the following "noncoordinated, excepted benefits" if the benefits meet state and federal regulations for excepted benefits and 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 the event under any group health plan maintained by the same plan sponsor:

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

(B) Hospital indemnity or other fixed indemnity insurance;

(v) "Health insurance coverage" does not include the following "supplemental, excepted

benefits" if offered as a separate policy, certificate, or contract of insurance under state and federal regulations:

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

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

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

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

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

(i) Health status;

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

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

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

(viii) Disability;

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

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

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

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

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

(ii) A special enrollment period;

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

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

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

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

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

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

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

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

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

(27) "Preventive services" means those services described in 42 U.S.C. § 300gg-13 and the implementing regulations and guidance, and shall be covered without any cost sharing for the enrollee when delivered by in-network providers, as those terms and obligations are therein described. If such authorities are no longer in effect, the immediately prior version of such authorities shall control. The commissioner shall determine which federally-recommended evidence-based services qualify as preventive care to the extent that federal recommendations change after January 1, 2019.

~~(27)~~(28) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

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

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

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

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

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

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

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

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

~~(d) Except as otherwise provided in subsection (e) of this section, for purposes of~~

~~applying paragraph (a)(1)(iii) of this section, a group health plan and a health insurance carrier offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period.~~

~~(e)(1) A group health plan or a health insurance carrier offering group health insurance may elect to apply paragraph (a)(1)(iii) of this section based on coverage of benefits within each of several classes or categories of benefits. Those classes or categories of benefits are to be determined by the secretary of the United States Department of Health and Human Services pursuant to regulation. The election shall be made on a uniform basis for all participants and beneficiaries. Under the election, a group health plan or carrier shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.~~

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

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

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

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

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

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

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

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

~~(g)(1) A group health plan and a health insurance carrier offering group health insurance~~

~~coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, as of the last day of the thirty (30) day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.~~

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

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

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

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

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

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

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

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

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

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

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

~~accordance with this subsection.~~

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

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

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

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

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

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

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

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

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

~~subsection.~~

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

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

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

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

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

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

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

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

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

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

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

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

~~(m) For the purpose of determining creditable coverage pursuant to this chapter, no~~

~~period before July 1, 1996, shall be taken into account. Individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have the coverage credited but for the prohibition in the preceding sentence may be given credit for creditable coverage for those periods through the presentation of documents or other means in accordance with any rule or regulation that may be established by the secretary of the United States Department of Health and Human Services.~~

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

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

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

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

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

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

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

(3) The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted by the ~~director~~ commissioner

pursuant to rule or regulation;

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

(5) The ~~director~~ commissioner finds that the continuation of the coverage would:

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

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

(6) In the case of a health insurance carrier that offers health insurance coverage in the large group market through a restricted provider network plan, there is no longer any enrollee in connection with that plan who resides, lives, or works in the service area of the carrier (or in an area for which the carrier is authorized to do business); and

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

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

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

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

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

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

(1) Provide advance notice to the ~~director~~ commissioner, to the insurance commissioner in each state in which the carrier is licensed, and to each plan sponsor (and participants and beneficiaries covered under that coverage and to the insurance commissioner in each state in which an affected insured individual is known to reside) of the decision at least one hundred

eighty (180) days prior to the date of the discontinuation of coverage. Notice to the insurance commissioner shall be provided at least three (3) working days prior to the notice to the affected plan sponsors, participants, and beneficiaries; and

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

(e) In the case of a discontinuation under subsection (d) of this section, the carrier shall be prohibited from the issuance of any health insurance coverage in the large group market in this state for a period of five (5) years from the date of notice to the ~~director~~ commissioner.

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

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

27-18.6-6. Applicability -- Exclusion of certain plans.

(a) The requirements of this chapter do not apply to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan does not meet the definition of large employer and is subject to the provisions of chapter 50 of this title.

(b)(1) The requirements of this chapter apply with respect to group health plans only:

(i) In the case of a plan that is a nonfederal governmental plan; and

(ii) With respect to group health insurance coverage offered in connection with a group health plan (including a plan that is a church plan or a governmental plan).

(2) If the plan sponsor of a nonfederal governmental plan which is a group health plan to which this chapter otherwise applies makes an election (in the form and manner as the secretary of the United States Department of Health and Human Services may prescribe by regulation), then the requirements of this subsection insofar as they apply directly to group health plans (and not merely to group health insurance coverage) do not apply to those governmental plans for the period except as provided in this section.

(3) An election applies for a single specified plan year (which may be extended through subsequent elections), or in the case of a plan provided pursuant to a collective bargaining agreement, for the term of that agreement.

(4) Under the election in subdivision (3), the plan shall provide for notice to enrollee (on

an annual basis and at the time of enrollment under the plan) of the fact and consequences of the election, and certification and disclosure of creditable coverage under the plan with respect to enrollees ~~in accordance with § 27-18.6-3(i)~~.

(c) The requirements of this chapter do not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of limited, excepted benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, or are not an integral part of the plan.

(d) The requirements of this chapter do not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of noncoordinated, excepted benefits if all of the following conditions are met:

(1) The benefits are provided under a separate policy, certificate, or contract of insurance;

(2) There is no coordination between the provision of benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(3) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to that event under any group health plan maintained by the same plan sponsor.

(e) The requirements of this chapter do not apply to any group health plan (and group health insurance coverage) in relation to its provision of supplemental, excepted benefits if the benefits are provided under a separate policy, certificate, or contract of insurance.

(f)(1) For purposes of this chapter, any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care (including items and services paid as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund or program), directly or through insurance, reimbursement, or otherwise, shall be treated as an employee welfare benefit plan which is a group health plan.

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

(3) In the case of a group health plan, the term "participant" also includes:

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

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual, if that individual is, or may become, eligible to receive a benefit under the plan or the individual's

beneficiaries may be eligible to receive any benefits.

27-18.6-7. Collective bargaining agreements.

(a) Notwithstanding anything contained in this chapter to the contrary, ~~except as provided in § 27-18.6-3(n),~~ in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before July 13, 2000, this chapter does not apply to plan years beginning before the later of:

(1) The date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension of the collective bargaining agreement agreed to after July 13, 2000); or

(2) July 1, 1997.

(b) For purposes of subdivision (a)(1) of this section, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of this chapter shall not be treated as a termination of the collective bargaining agreement.

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

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

27-18.6-9. Rules and regulations.

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

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

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

(a) A nonprofit hospital service corporation shall provide a summary of benefits and coverage explanation and definitions to policyholders and others required by, and at the times and in the format required, by the federal regulations adopted under section 2715 of the Public Health

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

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

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

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

(a) Annual limits.

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

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

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

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

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

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

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

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

(b) Lifetime limits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~section. Nothing in this section shall be construed to limit the authority of the commissioner under existing state law.~~

27-20-59. Annual and lifetime limits.

(a) Annual limits.

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

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

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

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

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

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

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

(b) Lifetime limits.

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

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

in accordance with federal laws and regulations.

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

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

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

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

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

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

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

(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.

SECTION 7. Sections 27-41-29.1, 27-41-76 and 27-41-78 of the General Laws in

Chapter 27-41 entitled "Health Maintenance Organizations" are hereby amended to read as follows:

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

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

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

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

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

(a) Annual limits.

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

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

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

~~(2) For plan or policy years beginning on or after January 1, 2014, a~~ A health

maintenance organization shall not establish any annual limit on the dollar amount of essential health benefits for any individual, except:

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

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

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

(b) Lifetime limits.

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

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

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

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

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

limited benefit policies.

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

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

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

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

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

27-50-3. Definitions.

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

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

(b) "Actuarial value" means the level of coverage of a plan, determined on the basis that

the essential health benefits are provided to a standard population.

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

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

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

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

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

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

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

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

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

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

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

(7) Has a constitution and bylaws; and

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

~~(f)~~(h) "Carrier" or "small employer carrier" means all entities licensed, or required to be licensed, in this state that offer health benefit plans covering eligible employees of one or more small employers pursuant to this chapter. For the purposes of this chapter, carrier includes an

insurance company, a nonprofit hospital or medical service corporation, a fraternal benefit society, a health maintenance organization as defined in chapter 41 of this title or as defined in chapter 62 of title 42, or any other entity subject to state insurance regulation that provides medical care as defined in subsection ~~(y)~~(x) that is paid or financed for a small employer by such entity on the basis of a periodic premium, paid directly or through an association, trust, or other intermediary, and issued, renewed, or delivered within or without Rhode Island to a small employer pursuant to the laws of this or any other jurisdiction, including a certificate issued to an eligible employee which evidences coverage under a policy or contract issued to a trust or association.

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

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

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

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

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

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

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

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

(i) A group health plan;

(ii) A health benefit plan;

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

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

(v) 10 U.S.C. § 1071 et seq., (medical and dental care for members and certain former members of the uniformed services, and for their dependents) (Civilian Health and Medical

Program of the Uniformed Services) (CHAMPUS). For purposes of 10 U.S.C. § 1071 et seq., "uniformed services" means the armed forces and the commissioned corps of the National Oceanic and Atmospheric Administration and of the Public Health Service;

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

(vii) A state health benefits risk pool;

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

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

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

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

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

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

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

~~(m)~~(p) ~~"Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the term shall also include an employee who works on a full-time basis with a normal work week of anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this eligibility criterion is applied uniformly among all of the employer's employees and without regard to any health status-related factor. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis or who works less than seventeen and one-half (17.5) hours per week. Any retiree under contract with any independently incorporated fire district is also included in the definition of eligible employee, as well as any former employee of an employer who retired before normal retirement age, as defined by 42 U.S.C. 18002(a)(2)(c) while~~

~~the employer participates in the early retiree reinsurance program defined by that chapter. Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation requirements pursuant to § 27-50-7(d)(9).~~ "Employee" means an individual employed by an employer.

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

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

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

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

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

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

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

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

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

~~(1) Enrollee;~~

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

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

~~(4) Enrollee and children.~~

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

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

~~(s)~~(u)(1) "Group health plan" means an employee welfare benefit plan as defined in § 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), to the extent that the plan provides medical care, as defined in subsection ~~(y)~~(x) of this section, and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(2) For purposes of this chapter:

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

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

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

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

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

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

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

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

those;

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

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

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

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

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

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

(i) Limited scope dental or vision benefits;

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

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

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

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

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

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

(1) Health status;

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

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

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

(8) Disability.

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

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

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

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

~~(B) The individual lost creditable coverage as a result of cessation of employer contribution, termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of creditable coverage, or death of a spouse, divorce or legal separation, or the individual and/or dependents are determined to be eligible for RIteCare under chapter 5.1 of title 40 or chapter 12.3 of title 42 or for RIteShare under chapter 8.4 of title 40; and~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ee) "Preventive services" means those services described in 42 U.S.C. section 300gg-13 and implementing regulations and guidance, and shall be covered without any cost sharing for the enrollee when delivered by in-network providers, as those terms and obligations are therein

described. If such authorities are no longer in effect, the immediately prior version of such authorities shall control. The commissioner shall determine which federally-recommended evidence-based services qualify as preventive care to the extent that federal recommendations change after January 1, 2019.

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

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

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

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

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

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

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

~~provisions of this chapter that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term small employer includes a self-employed individual.~~ to the extent allowed by federal law and regulation in connection with a group health plan with respect to a calendar year and a plan year, an employer who is a self-employed individual or an entity who employed an average of at least one but not more than fifty (50) employees on business days during the preceding calendar year, and is a self-employed individual or an entity who employs at least one employee on the first day of the plan year.

(2) Special rules for determining small employer status:

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

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

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

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

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

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

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

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

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

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

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

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

27-50-4. Applicability and scope.

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

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

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

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

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

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

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

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

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

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

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

~~(i) Age;~~

~~(ii) Gender; and~~

~~(iii) Family composition;~~ age. The age of an enrollee shall be determined as of the date of plan issuance or renewal.

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

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

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

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

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

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

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

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

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

Changes to the health benefit plan requested by the small employer.

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

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

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

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

~~(f)~~(e) The health insurance commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are

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

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

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

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

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

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

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

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

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

~~competent jurisdiction.~~

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

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

27-50-6. Renewability of coverage.

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

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

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

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

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

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

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

(ii) Provides notice of the decision to:

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

(B) The insurance commissioner in each state in which an affected insured individual is known to reside at least one hundred and eighty (180) days prior to the ~~nonrenewal~~ non-renewal

of any health benefit plans by the carrier, provided the notice to the commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected small employers and enrollees and their dependents;

(6) The ~~director~~ commissioner:

(i) Finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier's ability to meet its contractual obligations; and

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

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

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

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

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

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

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

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

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

(c)(1) A small employer carrier that elects to discontinue offering health benefit plans under subdivision (a)(5) of this section is prohibited from writing new business in the small employer market in this state for a period of five (5) years beginning on the date ~~the carrier ceased offering new coverage in this state~~ of discontinuance of the last coverage not renewed.

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

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

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

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

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

27-50-7. Availability of coverage.

~~(a) Until October 1, 2004, for purposes of this section, "small employer" includes any person, firm, corporation, partnership, association, or political subdivision that is actively engaged in business that on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed a combination of no more than fifty (50) and no less than two (2) eligible employees and part-time employees, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona~~

~~fide employer-employee relationship exists. After October 1, 2004, for the purposes of this section, "small employer" has the meaning used in § 27-50-3(kk).~~

~~(b)~~(a)(1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, ~~actively~~ offer to small employers all health benefit plans ~~it actively markets~~ that are approved for sale to small employers in this state ~~including a wellness health benefit plan. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to any small employer not currently receiving a health benefit plan from the small employer carrier~~, and must accept any small employer that applies for any of those health benefit plans subject to the provisions of this chapter. Such plans shall offer coverage of essential health benefits.

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

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

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

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

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

~~(2)(i) Except as provided in subdivision (3) of this subsection, a small employer carrier shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage without regard to the specific benefits covered during the period of creditable coverage, provided that the last period of creditable coverage ended on a date not more than~~

~~ninety (90) days prior to the enrollment date of new coverage.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

described in ~~item (C)(II) of this paragraph~~ subsection (c)(3)(ii) of this section.

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

~~(8)(i)~~(d)(1) A small employer carrier that makes coverage available under a group health plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in ~~paragraph (ii) of this subdivision~~ this section during which the person or, if not enrolled, the individual may be enrolled under the group health plan as a dependent of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is eligible for coverage if:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(h) No small group carrier may impose a pre-existing condition exclusion pursuant to the provisions of subdivisions 27-50-7(d)(1), 27-50-7(d)(2), 27-50-7(d)(3), 27-50-7(d)(4), 27-50-7(d)(5) and 27-50-7(d)(6) with regard to an individual that is less than nineteen (19) years of age. With respect to health benefit plans issued on and after January 1, 2014 a small employer carrier shall offer and issue coverage to small employers and eligible individuals notwithstanding any pre-existing condition of an employee, member, or individual, or their dependents.~~

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

27-50-8. Certification of creditable coverage.

(a) Small employer carriers shall provide written certification of creditable coverage to individuals in accordance with subsection (b) of this section.

(b) The certification of creditable coverage shall be provided:

(1) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(2) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(3) At the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in subdivision (1) or (2) of this subsection, whichever is later.

(c) Small employer carriers may provide the certification of creditable coverage required under subdivision (b)(1) of this section at a time consistent with notices required under any applicable COBRA continuation provision.

(d) The certificate of creditable coverage required to be provided pursuant to subsection (a) shall contain:

(1) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

(2) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

(e) To the extent medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under subsection (a) of this section if the carrier offering the coverage provides for certification in accordance with subsection (b) of this section.

~~(f)(1) If an individual enrolls in a group health plan that uses the alternative method of~~

~~counting creditable coverage pursuant to § 27-50-7(c)(3) of this act and the individual provides a certificate of coverage that was provided to the individual pursuant to subsection (b) of this section, on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity's health benefit plan.~~

~~(2) The entity providing the information pursuant to subdivision (1) of this subsection may charge the requesting group health plan the reasonable cost of disclosing the information.~~

27-50-11. Administrative procedures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27-50-15. Restoration of terminated coverage.

The ~~director~~ commissioner may promulgate regulations to require small employer carriers, as a condition of transacting business with small employers in this state after July 13, 2000, to reissue a health benefit plan to any small employer whose health benefit plan has been

terminated or not renewed by the carrier on or after July 1, 2000. The ~~director~~ commissioner may prescribe any terms for the reissue of coverage that the ~~director~~ commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

SECTION 9. Section 27-69-2 of the General Laws in Chapter 27-69 entitled "Mandated Benefits" is hereby amended to read as follows:

27-69-2. Definitions.

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

(b) "Health plan" shall mean "health insurance coverage" as defined in ~~subsections 27-18.5-2(8)(i)~~ §§ 27-18.5-2(8)(i) and ~~27-18.6-2(16)(i)~~ 27-18.6-2 or "health benefit plan" as defined in § 27-50-3.

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

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

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

42-14.5-3. Powers and duties.

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

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

(b) To make recommendations to the governor and the house of representatives and senate finance committees regarding health-care insurance and the regulations, rates, services, administrative expenses, reserve requirements, and operations of insurers providing health insurance in the state, and to prepare or comment on, upon the request of the governor or chairpersons of the house or senate finance committees, draft legislation to improve the regulation of health insurance. In making the recommendations, the commissioner shall recognize that it is the intent of the legislature that the maximum disclosure be provided regarding the reasonableness of individual administrative expenditures as well as total administrative costs. The commissioner shall make recommendations on the levels of reserves, including consideration of: targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess reserves.

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

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

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

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

(3) The uniform health plan claim form utilized by participating providers;

(4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit hospital or medical-service corporations, as defined by chapters 19 and 20 of title 27, to make facility-specific data and other medical service-specific data available in reasonably consistent formats to patients regarding quality and costs. This information would help consumers make informed choices regarding the facilities and clinicians or physician practices at which to seek care. Among the items considered would be the unique health services and other public goods provided by facilities and clinicians or physician practices in establishing the most appropriate cost comparisons;

(5) All activities related to contractual disclosure to participating providers of the mechanisms for resolving health plan/provider disputes;

(6) The uniform process being utilized for confirming, in real time, patient insurance enrollment status, benefits coverage, including co-pays and deductibles;

(7) Information related to temporary credentialing of providers seeking to participate in the plan's network and the impact of the activity on health-plan accreditation;

(8) The feasibility of regular contract renegotiations between plans and the providers in their networks; and

(9) Efforts conducted related to reviewing impact of silent PPOs on physician practices.

(e) To enforce the provisions of Title 27 and Title 42 as set forth in § 42-14-5(d).

(f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The fund shall be used to effectuate the provisions of §~~§ 27-18.5-9 and~~ 27-50-17.

(g) To analyze the impact of changing the rating guidelines and/or merging the individual health-insurance market, as defined in chapter 18.5 of title 27, and the small-employer-health-insurance market, as defined in chapter 50 of title 27, in accordance with the following:

(1) The analysis shall forecast the likely rate increases required to effect the changes recommended pursuant to the preceding subsection (g) in the direct-pay market and small-employer-health-insurance market over the next five (5) years, based on the current rating structure and current products.

(2) The analysis shall include examining the impact of merging the individual and small-employer markets on premiums charged to individuals and small-employer groups.

(3) The analysis shall include examining the impact on rates in each of the individual and small-employer health-insurance markets and the number of insureds in the context of possible changes to the rating guidelines used for small-employer groups, including: community rating principles; expanding small-employer rate bonds beyond the current range; increasing the employer group size in the small-group market; and/or adding rating factors for broker and/or tobacco use.

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

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

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

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

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

(h) To establish and convene a workgroup representing health-care providers and health insurers for the purpose of coordinating the development of processes, guidelines, and standards to streamline health-care administration that are to be adopted by payors and providers of health-care services operating in the state. This workgroup shall include representatives with expertise who would contribute to the streamlining of health-care administration and who are selected from hospitals, physician practices, community behavioral-health organizations, each health insurer, and other affected entities. The workgroup shall also include at least one designee each from the

Rhode Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the Rhode Island Health Center Association, and the Hospital Association of Rhode Island. The workgroup shall consider and make recommendations for:

(1) Establishing a consistent standard for electronic eligibility and coverage verification. Such standard shall:

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

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

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

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

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

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

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

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

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

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

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

(vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual

payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of detecting and deterring fraudulent billing activities. The guidelines shall require that each payor disclose to the provider its adjudication decision on a claim that was denied or adjusted based on the application of such edits and that the provider have access to the payor's review and appeal process to challenge the payor's adjudication decision.

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

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

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

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

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

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

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

(i) To issue an anti-cancer medication report. Not later than June 30, 2014 and annually thereafter, the office of the health insurance commissioner (OHIC) shall provide the senate committee on health and human services, and the house committee on corporations, with: (1) Information on the availability in the commercial market of coverage for anti-cancer medication options; (2) For the state employee's health benefit plan, the costs of various cancer-treatment

options; (3) The changes in drug prices over the prior thirty-six (36) months; and (4) Member utilization and cost-sharing expense.

(j) To monitor the adequacy of each health plan's compliance with the provisions of the federal Mental Health Parity Act, including a review of related claims processing and reimbursement procedures. Findings, recommendations, and assessments shall be made available to the public.

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

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

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

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

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

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

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

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

(1) Utilization review;

(2) Contracting; and

(3) Licensing and regulation.

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

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

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

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

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

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

27-18.5-11. Cost sharing requirements.

(a) Annual limitation on cost sharing.

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

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

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

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

(c) Premium adjustment percentage. The premium adjustment percentage is the percentage (if any) by which the average per capita premium for commercial health insurance coverage in Rhode Island for the preceding calendar year exceeds the average per capita premium

for commercial health insurance for 2019. The office of the health insurance commissioner shall publicly publish the annual premium adjustment percentage.

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

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

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

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

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

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

27-18.6-13. Compliance with federal law.

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

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

27-50-18. Cost sharing requirements.

(a) Annual limitation on cost sharing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(b) The wellness health benefit plan shall be determined by regulations promulgated by the office of health insurance commissioner (OHIC). The OHIC shall develop the criteria for the~~

~~wellness health benefit plan, including, but not limited to, benefit levels, cost sharing levels, exclusions, and limitations, in accordance with the following:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

~~The director may establish a payment mechanism to adjust for the amount of risk covered by each small employer carrier. The director may appoint an advisory committee composed of individuals that have risk adjustment and actuarial expertise to help establish the risk adjusters.~~

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

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

~~(b) The affordable health reinsurance program for small businesses shall only be available to low wage firms, as defined in § 27-50-3, who pay a minimum of fifty percent (50%), as defined in § 27-50-3, of single coverage premiums for their eligible employees, and who purchase the wellness health benefit plan pursuant to § 27-50-10. Eligibility shall be determined based on state and federal corporate tax filings. All eligible employees, as defined in § 27-50-3, employed by low wage firms as defined in § 27-50-3 (oo) shall be eligible for the reinsurance program if at least one low wage eligible employee as defined in regulation is enrolled in the employer's wellness health benefit plan.~~

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

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

~~(e) All carriers who participate in the Rhode Island RIte Care program as defined in § 42-12.3-4 and the procurement process for the Rhode Island state employee account, as described in chapter 36-12, must participate in the affordable health plan reinsurance program.~~

~~(f) The commissioner shall determine total eligible enrollment under qualifying small group health insurance contracts by dividing the funds available for distribution from the reinsurance fund by the estimated per member annual cost of claims reimbursement from the reinsurance fund.~~

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

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

~~(h) In the event the available funds in the affordable health reinsurance fund as created in § 42-14.5-3 are insufficient to satisfy all claims submitted to the fund in any calendar year, those claims in excess of the available funds shall be due and payable in the succeeding calendar year, or when sufficient funds become available whichever shall first occur. Unpaid claims from any prior year shall take precedence over new claims submitted in any one year.~~

~~(i) The commissioner shall provide the health maintenance organization, health insurers and health plans with notification of any enrollment suspensions as soon as practicable after receipt of all enrollment data. However, the suspension of issuance of qualifying small group health insurance contracts shall not preclude the addition of new employees of an employer already covered under such a contract or new dependents of employees already covered under such contracts.~~

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

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

SECTION 16. This act shall take effect upon passage and shall apply to health benefit plans issued or renewed on and after January 1, 2020.

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LC001782/SUB A
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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

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

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This act would establish the Rhode Island health insurance market stability and consumer protection act in order to update state law to reflect current insurance standards, practice and regulation to maintain market stability, including using current rating factors, continuing the use of a medical loss ratio standard, and providing coverage for benefits consistent with all applicable federal and state laws and regulations. Consumer protections contained in the act would include current requirements to: ban pre-existing condition exclusions; limit annual insurance coverage caps; coverage of preventive services without patient cost sharing, coverage of essential health benefits and provide summaries of benefits for consumers.

This act would take effect upon passage and shall apply to health benefit plans issued or renewed on and after January 1, 2020.

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