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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. 2015

A N A C T

RELATING TO INSURANCE -- HEALTH INSURANCE COVERAGE

Introduced By: Senators Sosnowski, Miller, Crowley, Sheehan, and Ottiano

Date Introduced: April 01, 2015

Referred To: Senate Health & Human Services

(OHIC)

It is enacted by the General Assembly as follows:

SECTION 1. Sections 27-18.5-1, 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:

27-18.5-1. Purpose. -- The purpose of this chapter is, among other things, to insure compliance of all policies, contracts, certificates, and agreements of individual health insurance coverage offered or delivered in this state with the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), and with the Affordable Care Act (Pub. L. 111-148).

27-18.5-2. Definitions. -- The following words and phrases as used in this chapter have the following meanings unless a different meaning is required by the context:

(1) "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 may prescribe by regulation;

~~(2) "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.;~~

~~(3) "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;~~

~~(4) "Director" means the director of the department of business regulation;~~

~~(5)~~(2) "Eligible individual" means an individual resident in 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;~~

~~(6)~~(3) "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)~~(4) "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, or 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)~~(5)(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:

(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 federal 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;~~

(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, and if the coverage complies with all other applicable state and federal laws and regulations:

(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 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 and if the coverage complies with all other applicable state and federal laws and regulations:

(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)~~(6) "Health status-related factor" means 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; and

(ix) Any other factor designated by the commissioner which he or she determines is susceptible to use as a health status-related factor.

~~(10)~~(7) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan;

~~(11)~~(8) "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)~~(9) "Preexisting condition" 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~~ 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) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), 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) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), 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

~~(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)~~(10) "Commissioner" means the health insurance commissioner.

27-18.5-3. Guaranteed availability to certain individuals. -- (a) Subject to subsections (b) through (h) of this section, ~~Notwithstanding any of the provisions of this title to the contrary,~~

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 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. ~~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~~ satisfaction of the 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~~ satisfaction of the 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) 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.

(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 or modifying applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

~~(g) OHIC may pursue federal funding in support of the development of a high risk pool 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. The components of the high risk pool program, 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.~~

~~(h)~~(g)(1) In the case of a health insurance carrier that offers health insurance coverage in the individual market through a restricted provider 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~~ geographic areas ~~for~~ which 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~~ satisfaction of the 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 at least a period of one hundred eighty (180) days after the coverage is denied, or for a longer period of time if so ordered by the commissioner.

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 or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) The individual 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 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 from the act or practice of the application, and the eligible individual has failed to reimburse the carrier for the premiums 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 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 plan policy form offered in the individual market, coverage ~~of that type~~ under that form 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~~.~~ ; and

(4) The commissioner determines the discontinuance is in the best interests of the public.

(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~~.~~ ; and

(3) The commissioner determines the discontinuance is in the best interests of the public.

(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~~ Rules and regulations; Compliance with federal laws and regulations. -- The ~~director~~ commissioner may promulgate rules and regulations necessary to effectuate the purposes of this chapter. A carrier shall comply with all federal laws and regulations relating to health insurance coverage in the individual market, as interpreted and enforced by the commissioner. The commissioner may establish additional standards relating to health insurance coverage in the individual market that the commissioner determines are necessary to provide greater protection for Rhode Island consumers, to ensure the stability and proper functioning of the individual health insurance market, and to clarify the meaning of the requirements of federal laws and regulations.

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

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

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

(b) As used in this section:

(1) ~~"Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition (whether physical or mental) was present before the effective date of coverage, or if the coverage is denied, the date of denial, under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was recommended or received before the effective date of coverage.~~ "Preexisting condition exclusion" means 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) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), 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) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), 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 exclusion" means any limitation or exclusion of benefits, including a denial of coverage, applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if the coverage is denied, the date of denial, under the health benefit plan, such as a condition (whether physical or mental) identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.~~

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

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

SECTION 2. 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 3. Sections 27-18.6-1, 27-18.6-2, 27-18.6-3, 27-18.6-5, 27-18.6-6 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:

27-18.6-1. Purpose. -- The purpose of this chapter is to insure compliance of all policies, contracts, certificates, and agreements of group health insurance coverage offered or delivered in this state with the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and with the Affordable Care Act (Pub. L. 111-148).

27-18.6-2. Definitions. -- The following words and phrases as used in this chapter have the following meanings 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) "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) "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) "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) "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)~~(4) "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) "Director" means the director of the department of business regulation;~~

(5) "Commissioner" means the health insurance commissioner;

~~(8)~~(6) "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)~~(7) "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)~~(8) "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)~~(9) "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)~~(10) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with that plan;

~~(13)~~(11) "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)~~(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, 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)~~(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. 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"; provided, such coverage is consistent with other applicable state and federal laws and regulations:

(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 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, and if the coverage complies with other applicable state and federal laws and regulations:

(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 federal regulations issued pursuant to P.L. 104-191;

(iv) "Health insurance coverage" does not include the following "noncoordinated, excepted 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, if the coverage complies with all other applicable state and federal laws and regulations, 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:

(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)~~(14) "Health maintenance organization" ("HMO") means a health maintenance organization licensed under chapter 41 of this title;

~~(17)~~(15) "Health status-related factor" means 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; and

(ix) Any other factor designated by the commissioner which he or she determines is susceptible to use as a health status-related factor.

~~(18)~~(16) "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~~;~~. Effective upon a determination by the commissioner that adopting the federal definition of "large employer" is in the best interests of policyholders, certificate holders, and the public, "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 one hundred one (101) 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)~~(17) "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)~~(18) "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)~~(19) "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)~~(20) "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)~~(21) "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)~~(22) "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)~~(23) "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)~~(24) "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~~ 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) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), 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) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), 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)~~(25) "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 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 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 the coverage application;

(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~~ geographic area which can be served by the providers and facilities that are participating in the restricted provider network plan, consistent with state and federal network adequacy requirements ~~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, 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~~.~~ ; and

(4) The commissioner determines the discontinuance is in the best interests of the public.

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

(1) Provide advance notice to the director, 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~~.~~ ; and

(3) Obtain the determination of the commissioner that discontinuance is in the best interests of the public.

(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, and if the plan complies with all other applicable state and federal laws and regulations.

(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, and if the plan complies with all other applicable state and federal laws and regulations 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, and if the plan complies with all other applicable state and federal laws and regulations.

(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.

27-18.6-9. Rules and regulations. -- The ~~director~~ commissioner may promulgate rules and regulations necessary to effectuate the purposes of this chapter.

SECTION 4. Chapter 27-18.6 of the General Laws entitled "Large Group Health Insurance Coverage" is hereby amended by adding thereto the following sections:

27-18.6-13. Waiting periods. -- At the election of the plan sponsor, the health coverage plan may provide for a waiting period applicable to all new enrollees under the plan, provided that the waiting period is no longer than ninety (90) days.

27-18.6-14. Compliance with federal law. -- A carrier shall comply with all federal laws

and regulations relating to health insurance coverage in the large group market, as interpreted by the commissioner. The commissioner may establish additional standards relating to health insurance coverage in the large group market that the commissioner determines are necessary to provide greater protection for Rhode Island consumers, to ensure the stability and proper functioning of the large group health insurance market, and to clarify the meaning of the requirements of federal laws and regulations.

SECTION 5. Sections 27-50-2, 27-50-3, 27-50-4, 27-50-5, 27-50-6, 27-50-7, 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:

27-50-2. Purpose. -- (a) The purpose and intent of this chapter are to enhance the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to prevent segmentation of the health insurance market based upon health risk, to spread health insurance risk more broadly, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to limit the use of preexisting condition exclusions, ~~to provide for development of "economy", "standard" and "basic" health benefit plans to be offered to all small employers,~~ and to improve the overall fairness and efficiency of the small group health insurance market.

(b) This chapter is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

27-50-3. Definitions. [Effective December 31, 2010.] -- (a) As used in this chapter:

(1) "Actuarial certification" means a written statement signed by a member of the American Academy of Actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of § 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)~~(2) "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)~~(3) "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)~~(4) "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)~~(5) "Bona fide association" means, with respect to health benefit plans offered in this state, an association which:

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

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

~~(3)~~(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);

~~(4)~~(iv) 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)~~(v) Does not make health insurance coverage offered through the association available other than in connection with a member of the association;

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

~~(7)~~(vii) Has a constitution and bylaws; and

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

~~(f)~~(6) "Carrier" or "small employer carrier" means all entities licensed, or required to be licensed, in this state that offer health benefit plans covering eligible employees of one or more small employers pursuant to this chapter. For the purposes of this chapter, carrier includes an insurance company, a nonprofit hospital or medical service corporation, a fraternal benefit society, a health maintenance organization as defined in chapter 41 of this title or as defined in chapter 62 of title 42, or any other entity subject to state insurance regulation that provides medical care as defined in subsection (y) that is paid or financed for a small employer by such entity on the basis of a periodic premium, paid directly or through an association, trust, or other intermediary, and issued, renewed, or delivered within or without Rhode Island to a small employer pursuant to the laws of this or any other jurisdiction, including a certificate issued to an eligible employee which evidences coverage under a policy or contract issued to a trust or association.

~~(g)~~(7) "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)_.

~~(h)~~(8) "Control" is defined in the same manner as in chapter 35 of this title.

~~(i) (1) "Creditable coverage" means, with respect to an individual, health benefits or~~

~~coverage provided under any of the following:~~

~~(i) A group health plan;~~

~~(ii) A health benefit plan;~~

~~(iii) Part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. § 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)~~(9) "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)~~(10) [Deleted by P.L. 2006, ch. 258, § 2, and P.L. 2006, ch. 296, § 2.]

~~(m)~~(11) "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, except that upon a determination by the commissioner that the exclusion of a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor as an eligible employee is in the best interests of the public, a self-employed individual, sole proprietor, partner, or independent contractor shall not be considered an eligible employee. 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). Upon a determination by the commissioner that a change in counting methodology is in the best interest of the public, employees will be counted for purposes of small group eligibility in accordance with federal laws and regulations.

~~(n)~~(12) "Enrollment date" means the first day of coverage or, if there is a waiting period, the first day of the waiting period, whichever is earlier.

~~(o)~~(13) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

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

~~(1) Enrollee;~~

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

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

~~(4) Enrollee and children.~~

~~(q)~~(14) "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)~~(15) "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)(1)~~(16) "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) 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)~~(i) For purposes of this chapter:

~~(i)~~(A) 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)~~ (B) of this subdivision, as an employee welfare benefit plan that is a group health plan;

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

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

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

~~(t)(1)~~(17) "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)~~(i) "Health benefit plan" does not include one or more, or any combination of, the following:

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

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

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

~~(iv)~~(D) Workers' compensation or similar insurance;

~~(v)~~(E) Automobile medical payment insurance;

~~(vi)~~(F) Credit-only insurance;

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

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

~~(3)~~(ii) "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, and if the plan is in compliance with all other applicable state and federal laws and regulations:

~~(i)~~(A) Limited scope dental or vision benefits;

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

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

~~(4)~~(iii) "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 if the plan is in compliance with all other applicable state and federal laws and regulations and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

~~(ii)~~(B) Hospital indemnity or other fixed indemnity insurance.

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

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

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

~~(iii)~~(C) 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)~~(18) "Health maintenance organization" or "HMO" means a health maintenance organization licensed under chapter 41 of this title.

~~(v)~~(19) "Health status-related factor" means any of the following factors:

~~(1)~~(i) Health status;

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

~~(3)~~(iii) Claims experience;

~~(4)~~(iv) Receipt of health care;

~~(5)~~(v) Medical history;

~~(6)~~(vi) Genetic information;

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

~~(8)~~(viii) Disability.

~~(w)(1)~~(20) "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)~~(i) "Late enrollee" does not mean an eligible employee or dependent:

~~(i)~~(A) 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)~~(I) 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)~~(II) 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)~~(III) 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)~~(IV) 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)~~(V) If the individual had coverage under a COBRA continuation provision and the coverage under that provision has been exhausted; or

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

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

~~(1)~~(i) 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)~~(ii) Transportation primarily for and essential to medical care referred to in subdivision ~~(1)~~ (i); and

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

~~(z)~~(23) "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)~~(24) "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)~~(25) "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)~~(26) "Preexisting condition" means 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) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), 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) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), 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 ~~condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the enrollment date of the coverage~~.

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

~~(3)~~(i) 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)~~(27) "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)~~(28) "Producer" means any insurance producer licensed under chapter 2.4 of this title.

~~(ff)~~(29) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~(gg)~~(30) "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)~~(31) "Risk adjustment mechanism" means the mechanism established pursuant to § 27-50-16.

~~(ii)~~(32) "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)~~(33) "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. Effective upon a determination by the commissioner that a revision in the definition of "small employer" is in the best interests of the public, "small employer" means a small group under federal laws and regulations.

~~(ll)~~(34) "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)~~(35) "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)~~(36) "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 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 under this title shall apply if a small employer carrier cedes or assumes all 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, or if the commissioner determines that the level of risk ceded or assumed may jeopardize the assurance of benefits to be provided to policyholders and certificate holders, or may jeopardize the financial condition of the carrier.

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 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~~ Tobacco use, in accordance with a program approved by the commissioner; and

(iii) ~~Family composition~~ Participation in a disease management or wellness program approved by the commissioner~~;~~ .

(2) The adjustment for age in paragraph (1)(i) of this subsection may not use age brackets smaller than ~~five (5)~~ one year increments and these shall begin with age ~~thirty (30)~~ nineteen (19) and end with age sixty-five (65).

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

(4) For each health benefit plan offered by a carrier, the highest premium rate for each ~~family composition type~~ age 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) The provisions relating to 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) 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 §§ 27-19-6, 27-20-6, 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, and submitted to the commissioner in connection with any changes to the carrier's rate

manual.

(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;

(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, and the commissioner determines the discontinuance is in the best interests of the public, 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 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:

(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, and the commissioner determines the discontinuance is in the best interests of the public, if the carrier:

(i) Provides notice of the decision not to renew coverage at least ninety (90) days prior to the nonrenewal 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.

(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.

(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 all of its existing business in the small employer market in the state.

(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)~~(33).

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

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

(c)(1) ~~A~~ Subject to the provisions of §§ 27-18-8, 27-19-7.2, 27-20-62, and 27-41-29.2, a small employer carrier shall file with the ~~director~~ commissioner, in a format and manner prescribed by the ~~director~~ commissioner, 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~~ commissioner 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)~~(i) 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)~~(ii) 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)~~(2) A small employer carrier shall permit an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the group health plan of the small employer during a special enrollment period if:

~~(A)~~(i) 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)~~(ii) 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)~~(iii) The employee's or dependent's coverage described under subparagraph (A) of this paragraph:

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

~~(II)~~(B) 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)~~(iv) 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)~~ (iii)(A) of this paragraph or termination of coverage or employer contribution described in item ~~(C)(II)~~ (iii)(B) of this paragraph.

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

~~(8)(i)~~(3) 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)~~ (3)(A) of this subdivision during which the person or, if not enrolled, the individual may be enrolled under the group health plan as a dependent of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is eligible for coverage if:

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

~~(A)~~(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)~~ (3)(ii) of this subdivision.

~~(iii)~~(B) If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period described under paragraph ~~(ii)~~ (3)(A) of this subdivision, 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)~~(4) 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)~~(i) 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)~~(ii) 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)~~(iii) 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)~~(5) 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)~~(i) 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)~~(ii) Except as otherwise permitted under ~~subdivisions (1) and (4) of~~ this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services covered by the plan.

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

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

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

(iii) ~~Within~~ 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~~ may not offer coverage in the applicable area to new cases of employer groups until the later of one hundred and eighty (180) days following each refusal or the date on which the carrier notifies the director that it has regained capacity to deliver services to new employer groups.

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

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

(1)(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)(1) A small employer carrier is not required to provide coverage to small employers pursuant to subsection (b) of this section if the small employer carrier, 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) shall provide at least one hundred and twenty (120) days notice of its election to the director and is prohibited from writing new business in the small employer market

in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

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

27-50-11. Administrative procedures. -- The ~~director~~ commissioner shall issue regulations in accordance with chapter 35 of this title for the implementation and administration of the Small Employer Health Insurance Availability Act.

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) 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) 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) 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) The director 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) (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 6. Sections 27-50-8, 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.

~~**27-50-8. 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.~~

~~**27-50-9. 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 7. 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. Compliance with federal law. -- A carrier shall comply with all federal laws and regulations relating to health insurance coverage in the small group market, as interpreted and

enforced by the commissioner. The commissioner may establish additional standards relating to health insurance coverage in the small group market that the commissioner determines are necessary to provide greater protection for Rhode Island consumers, to ensure the stability and proper functioning of the small group health insurance market, and to clarify the meaning of the requirements of federal laws and regulations.

SECTION 8. This act shall take effect upon passage, and shall apply to small employer health benefit plans issued on and after January 1, 2016.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- HEALTH INSURANCE COVERAGE

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This act transfers jurisdiction over health insurance regulation from the director of business regulation to the office of health insurance commissioner. The act also amends statutory provisions related to health insurance to be consistent with the Affordable Care Act.

This act would take effect upon passage, and would apply to small employer health benefit plans issued on and after January 1, 2016.

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