# 2018 -- S 2785 SUBSTITUTE A

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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. 2018**

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A N  A C T

RELATING TO INSURANCE -- INDIVIDUAL HEALTH INSURANCE COVERAGE

Introduced By: Senators Miller, Coyne, DiPalma, Goldin, and Ruggerio

Date Introduced: April 05, 2018

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Section 27-18.5-2 of the General Laws in Chapter 27-18.5 entitled "Individual Health Insurance Coverage" is hereby amended to read as follows:

**27-18.5-2. Definitions.**

The following words and phrases as used in this chapter have the following meanings 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) "Eligible individual" means an individual:

(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) "Essential Health Benefits" means the following general categories and the items and services covered within the following ten (10) categories that are consistent with the Rhode Island benchmark plan. The commissioner, in their discretion, shall periodically define a benchmark plan. The essential health benefits shall provide:

(i) Ambulatory patient services;

(ii) Emergency services;

(iii) Hospitalization;

(iv) Maternity and newborn care;

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

(vi) Prescription drugs;

(vii) Rehabilitative and habilitative services and devices;

(viii) Laboratory services;

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

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

~~(6)~~(7) "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)~~(8) "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 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)~~(9) (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;

(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:

(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:

(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)~~(10) "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;

~~(10)~~(11) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan;

~~(11)~~(12) "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)~~(13) "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; ~~and~~

(14) "Preventive services" means those services described in 42 USC § 300gg-13 and implementing regulations and guidance, and shall be covered without any cost-sharing for the enrollee when delivered by in-network providers, as those terms and obligations are therein described, and if repealed then the preventive services as may be described in 26 USC § 223 relating to the Internal Revenue Service High Deductible Health Plan Safe Harbor Rules;

~~(13)~~(15) "High-risk individuals" means those individuals who do not pass medical underwriting standards, due to high health care needs or risks;

~~(14)~~(16) "Wellness health benefit plan" means that health benefit plan offered in the individual market pursuant to § 27-18.5-8; ~~and~~

~~(15)~~(17) "Commissioner" means the health insurance commissioner.

SECTION 2. Chapter 27-18.5 of the General Laws entitled "Individual Health Insurance Coverage" is hereby amended by adding thereto the following section:

**27-18.5-11. Essential health benefits -- Individual.**

A health insurance policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a resident of this state by a health insurance company licensed pursuant to this title and/or chapter shall provide coverage of at least the ten (10) essential health benefits categories set forth in § 27-18.5-2(6) under the cost-sharing requirements of § 27-18.5-2(14). The commissioner shall have the authority to promulgate rules and regulations for the implementation of this chapter, including the authority to not approve any plan that they determine does not appropriately comply with or substantially provide for the essential health benefits.

SECTION 3. Chapter 27-50 of the General Laws entitled "Small Employer Health Insurance Availability Act" is hereby amended by adding thereto the following sections:

**27-50-18. Essential health benefits -- Small employer.**

A health insurance policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a resident of this state by a health insurance company licensed pursuant to this title and/or chapter shall provide coverage of at least the ten (10) essential health benefits categories set forth at § 27-18.5-2(6) under the cost-sharing requirements of § 27-18.5-2(14). The commissioner shall have the authority to promulgate rules and regulations for the implementation of this chapter, including the authority to not approve any plan that they determine does not appropriately comply with or substantially provide for the essential health benefits.

**27-50-19. Small business health options program (SHOP) innovation waiver.**

(a) Finding of fact. As small business owners and sole proprietors are the life blood of this state's economy, a recent change in the Federal Affordable Care Act effective on January 1, 2016, has caused irreparable harm to the economic well-being of some small business owners and sole proprietors by requiring them to secure health insurance coverage on the individual market as opposed to securing health insurance coverage on the small group market.

(b) The director of the department of administration, with assistance from the commissioner of health insurance (OHIC), is authorized to seek a waiver under Section 1332 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, for the purpose of allowing businesses classified as self-employed and sole proprietors to purchase insurance in the small group market through the Health Source RI for Employers small business health options program (SHOP) and not be forced into the individual market. Submission of such a waiver application shall be contingent upon an assessment by OHIC of the costs and impacts on small businesses in general.

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

**27-18.6-13. Essential health benefits.**

A health insurance policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a resident of this state by a health insurance company licensed pursuant to this title and/or chapter shall provide coverage of at least the ten (10) essential health benefits categories set forth at § 27-18.5-2(6) under the cost-sharing requirements of § 27-18.5-2(14). The commissioner shall have the authority to promulgate rules and regulations for the implementation of this chapter, including the authority to not approve any plan that they determine does not appropriately comply with or substantially provide for the essential health benefits.

SECTION 5. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO INSURANCE -- INDIVIDUAL HEALTH INSURANCE COVERAGE

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This act would provide that health insurance plans provide coverage for certain essential health benefit categories which are consistent with the Rhode Island benchmark plan.

This act would take effect upon passage.

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