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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. 2022

A N A C T

RELATING TO INSURANCE -- INDIVIDUAL HEALTH INSURANCE COVERAGE

Introduced By: Representatives Cassar, McNamara, Kislak, Speakman, J Lombardi, Potter, Felix, Amore, Ajello, and Donovan
Date Introduced: February 16, 2022

Referred To: House Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Sections 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:

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

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

~~condition) and~~ any eligible applicant. For the purposes of this section, an "eligible applicant" means any individual resident of this state. A carrier offering health insurance coverage in the individual market must offer to any eligible applicant in the state all health insurance coverage plans of that carrier that are approved for sale in the individual market and must accept any eligible applicant 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 all policy forms of health insurance coverage to all eligible applicants. Provided, a carrier may offer plans with reduced cost sharing for qualifying eligible applicants, based on available federal funds including those described by 42 U.S.C. § 18071, or based on a program established with state funds. ~~Provided, the carrier may elect to limit the coverage offered so long as it offers at least two (2) different policy forms of health insurance coverage (policy forms which have different cost-sharing arrangements or different riders shall be considered to be different policy forms) both of which:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) 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 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)(1) In the case of a health insurance carrier that offers health insurance coverage in the individual market through a network plan, the carrier may limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service areas for the network plan; and within the service areas of the plan, deny coverage to individuals if the carrier has demonstrated to the director that:

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

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

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

(i) A carrier must allow an eligible applicant to enroll in coverage during:

(1) An open enrollment period to be established by the commissioner and held annually for a period of between thirty (30) and sixty (60) days;

(2) Special enrollment periods as established in accordance with the version of 45 C.F.R. § 147.104 in effect on January 1, 2022; and

(3) Any other open enrollment periods or special enrollment periods established by federal or state law, rule or regulation.

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

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

(b) A health insurance carrier may ~~nonrenew~~ non-renew or discontinue health insurance coverage of an 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, including terms relating to ~~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;

(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 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 offered in the individual market, coverage of that type may be discontinued only if:

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

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

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

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

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

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

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

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

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

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

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

27-18.5-6. Rules and regulations.

The ~~director~~ commissioner may promulgate rules and regulations necessary to effectuate the purposes of this chapter.

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

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

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

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

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

~~(1) "Preexisting~~ preexisting condition exclusion" ~~means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition (whether physical or~~

~~mental) was present before the effective date of coverage, or if the coverage is denied, the date of denial, under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was recommended or received before the effective date of coverage.~~

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

(c) 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. 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) The following words and phrases, as used in this section, have the following meanings consistent with federal law and regulations adopted thereunder, as long as they remain in effect. If such authorities are no longer in effect, the laws and regulations in effect on January 1, 2022, as identified by the commissioner, shall govern, unless a different meaning is required by the context:

(1) "Essential health benefits" means the following general categories, and the services covered within those categories:

(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.

(2) "Preventive services" means those services described in 42 U.S.C. § 300gg-13 and implementing regulations and guidance. If such authorities are determined by the commissioner to no longer be in effect, and to the extent that federal recommendations change after January 1, 2022, the commissioner shall rely on the recommendations as described in the version of 42 U.S.C. § 300gg-13 in effect on January 1, 2022, to determine which services qualify as preventive services under this section.

(b) 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 essential health benefits categories set forth in this section, and shall further provide coverage of preventive services from in-network providers without applying any copayments, deductibles, coinsurance, or other cost sharing, as set forth in this section.

(c) This provision shall not be construed as authority to expand the scope of preventive services beyond those in effect on January 1, 2022; provided, however, to the extent that the U.S. Preventive Services Taskforce revises its recommendations with respect to grade "A" or "B" preventive services, the OHIC shall have the authority to issue guidance updating and/or clarifying the services that shall qualify as preventive services under this section, consistent with said recommendations.

SECTION 3. Chapter 27-18.6 of the General Laws entitled "Large Group Health Insurance Coverage" is hereby amended by adding thereto the following section:

27-18.6-3.1. Preventative services.

(a) As used in this section, "preventive services" means those services described in 42 U.S.C. § 300gg-13 and implementing regulations and guidance. If such authorities are determined by the commissioner to no longer be in effect, and to the extent that federal recommendations change after January 1, 2022, the commissioner shall rely on the recommendations as described in the version of 42 U.S.C. § 300gg-13 in effect on January 1, 2022, to determine which services qualify as preventive services under this section.

(b) 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 essential health benefits categories set forth in this section and shall further provide coverage of preventive services from in-network providers without applying any copayments, deductibles, coinsurance, or other cost sharing, as set forth in this section.

(c) This provision shall not be construed as authority to expand the scope of preventive services beyond those in effect on January 1, 2022; provided, however, except to the extent that the U.S. Preventive Services Taskforce revises its recommendations with respect to grade "A" or "B" preventive services, OHIC shall have the authority to issue guidance updating and/or clarifying the services that shall qualify as preventive services under this section, consistent with said recommendations.

SECTION 4. Section 27-50-11 of the General Laws in Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" is hereby amended to read as follows:

27-50-11. Administrative procedures.

The ~~director shall issue~~ commissioner may promulgate rules and regulations necessary to effectuate the purposes of this chapter ~~in accordance with chapter 35 of this title for the implementation and administration of the Small Employer Health Insurance Availability Act~~.

SECTION 5. 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. Essential health benefits.

(a) The following words and phrases, as used in this section, have the following meanings consistent with federal law and regulations adopted thereunder, as long as they remain in effect. If such authorities are no longer in effect, the laws and regulations in effect on January 1, 2022, as identified by the commissioner, shall govern, unless a different meaning is required by the context:

(1) "Essential health benefits" means the following general categories, and the services covered within those categories;

(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.

(2) "Preventative services" means those services described in 42 U.S.C. § 300gg-13 and implementing regulations and guidance. If such authorities are determined by the commissioner to

no longer be in effect, and to the extent that federal recommendations change after January 1, 2022, the commissioner shall rely on the recommendations as described in the version of 42 U.S.C. § 300gg-13 in effect on January 1, 2022, to determine which services qualify as preventive services under this section.

(b) 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 essential health benefits categories set forth in this section, and shall further provide coverage of preventive services from in-network providers without applying any copayments, deductibles, coinsurance, or other cost sharing set forth in this section.

(c) This provision shall not be construed as authority to expand the scope of preventive services beyond those in effect on January 1, 2022; provided, however, to the extent that the U.S. Preventive Services Taskforce revises its recommendations with respect to grade "A" or "B" preventive services, the OHIC shall have the authority to issue guidance updating and/or clarifying the services that shall qualify as preventive services under this section, consistent with said recommendations.

SECTION 6. Section 27-18-73 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" is hereby amended to read as follows:

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

(a) Annual limits.

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

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

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

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

(A) A health flexible spending arrangement, as defined in Section 106(c)(2)(i) of the Federal Internal Revenue Code, a medical savings account, as defined in section 220 of the federal Internal Revenue Code, and a health savings account, as defined in Section 223 of the federal

Internal Revenue Code are not subject to the requirements of subdivisions (1) and (2) of this subsection.

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

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

(b) Lifetime limits.

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

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

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

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

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

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

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

SECTION 7. Section 27-19-63 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby amended to read as follows:

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

(a) Annual limits.

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

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

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

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

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

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

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

(b) Lifetime limits.

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

(2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit plan is not prohibited from placing lifetime dollar limits for any individual on specific covered

benefits that are not essential health benefits in accordance with federal laws and regulations.

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

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

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

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

SECTION 8. Section 27-20-59 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby amended to read as follows:

27-20-59. Annual and lifetime limits.

(a) Annual limits.

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

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

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

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

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

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

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

(b) Lifetime limits.

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

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

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

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

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

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

policies.

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

SECTION 9. Section 27-41-76 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby amended to read as follows:

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

(a) Annual limits.

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

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

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

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

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

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

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

(b) Lifetime limits.

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

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

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

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

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

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

SECTION 10. This act shall take effect on January 1, 2024.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- INDIVIDUAL HEALTH INSURANCE COVERAGE

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This act would require individual health insurers, large group health insurers and small employer health insurers, to provide coverage for ten (10) categories of essential health benefits. The act would also revoke the authority of the health insurance commissioner to enforce a ruling of the federal government or federal court that revokes the prohibition on limits on health insurance.

This act would take effect on January 1, 2024.

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