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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. 2006

A N A C T

RELATING TO HEALTH AND SAFETY - HEALTH INSURANCE AFFORDABILITY AND TRANSPARENCY ACT OF 2006

Introduced By: Senator Leo R. Blais

Date Introduced: February 09, 2006

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. It is the intent of the general assembly to meet the goals of health insurance
2 affordability and transparency in the state. The general assembly finds and declares that:
3 (1) There has been a substantial erosion in employer-sponsored health insurance coverage
4 for working Rhode Islanders, particularly those employed by small businesses.
5 (2) The erosion in coverage is especially pronounced for low-wage workers, as small
6 business employers with average wages in the bottom quartile – are significantly less likely to
7 offer health insurance.
8 (3) The escalating costs of employer sponsored health coverage have made it difficult for
9 small businesses to offer and contribute to the health insurance coverage of workers and their
10 dependents and remain profitable.
11 (4) The erosion in employer sponsored health insurance has created significant local
12 market disruption:
13 (i) The rate of uninsured in Rhode Island has increased precipitously.
14 (ii) The number of individuals and families purchasing health coverage on their own,
15 outside of their employer has substantially increased.
16 (iii) State expenditures for RIte Care have risen far above anticipated levels.
17 (5) Current market rules and practices do not provide for affordable, cost-efficient plan
18 designs that create appropriate incentives for consumer, providers and health plans to address the

underlying cost of care in Rhode Island.

(6) The rise in individual coverage outside the employer-sponsored system currently places an inequitable and unsustainable financial burden on not-for-profit insurers in the individual market.

(7) In response to the escalating costs of private health insurance, many employers are beginning to switch to high deductible, high-cost sharing plans as a cost containment strategy. These plans place significant responsibility for cost-effective decision-making into the hands of the end consumer. However, today's consumers are ill-prepared for such decision-making--they lack the necessary tools and information to support cost-effective choices.

Wherefore, it is the intent of the general assembly to utilize state resources in a fair, efficient and economical manner to assist Rhode Islanders, wherever possible, to continue to utilize available affordable private employer-sponsored and individual health insurance coverage and to stabilize the insurance market for such coverage.

To respond to the disruption caused by the escalating cost of private health insurance and the erosion in employer-sponsored health insurance, it is the intent of the general assembly to ensure the availability of cost-efficient and affordable products; increase small business purchasing power; stabilize the market for individual health insurance; and promote transparency of information to allow for cost-effective decision-making.

SECTION 2. 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;

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

2 (vii) Has a constitution and bylaws; and

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

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

5 (i) Section 4980(B) of the Internal Revenue Code of 1986, 26 U.S.C. section 4980B,

6 other than subsection (f)(1) of that section insofar as it relates to pediatric vaccines;

7 (ii) Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of

8 1974, 29 U.S.C. section 1161 et seq., other than Section 609 of that act, 29 U.S.C. section 1169;

9 or

10 (iii) Title XXII of the United States Public Health Service Act, 42 U.S.C. section 300bb-

11 1 et seq.;

12 (3) "Creditable coverage" has the same meaning as defined in the United States Public

13 Health Service Act, Section 2701(c), 42 U.S.C. section 300gg(c), as added by P.L. 104-191;

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

15 (5) "Eligible individual" means an individual:

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

17 the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose

18 most recent prior creditable coverage was under a group health plan, a governmental plan

19 established or maintained for its employees by the government of the United States or by any of

20 its agencies or instrumentalities, or church plan (as defined by the Employee Retirement Income

21 Security Act of 1974, 29 U.S.C. section 1001 et seq.);

22 (ii) Who is not eligible for coverage under a group health plan, part A or part B of title

23 XVIII of the Social Security Act, 42 U.S.C. section 1395c et seq. or 42 U.S.C. section 1395j et

24 seq., or any state plan under title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq.

25 (or any successor program), and does not have other health insurance coverage;

26 (iii) With respect to whom the most recent coverage within the coverage period was not

27 terminated based on a factor described in section 27-18.5-4(b)(relating to nonpayment of

28 premiums or fraud);

29 (iv) If the individual had been offered the option of continuation coverage under a

30 COBRA continuation provision, or under chapter 19.1 of this title or under a similar state

31 program of this state or any other state, who elected the coverage; and

32 (v) Who, if the individual elected COBRA continuation coverage, has exhausted the

33 continuation coverage under the provision or program;

34 (6) "Group health plan" means an employee welfare benefit plan as defined in section

1 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the
2 extent that the plan provides medical care and including items and services paid for as medical
3 care to employees or their dependents as defined under the terms of the plan directly or through
4 insurance, reimbursement or otherwise;

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

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

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

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

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

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

21 (D) Workers' compensation or similar insurance;

22 (E) Automobile medical payment insurance;

23 (F) Credit-only insurance;

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

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

28 (I) Short term limited duration insurance;

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

32 (A) Limited scope dental or vision benefits;

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

1 (C) Any other similar, limited benefits that are specified in federal regulation issued
2 pursuant to P.L. 104-191;
3 (iv) "Health insurance coverage" does not include the following benefits if the benefits
4 are provided under a separate policy, certificate, or contract of insurance, there is no coordination
5 between the provision of the benefits and any exclusion of benefits under any group health plan
6 maintained by the same plan sponsor, and the benefits are paid with respect to an event without
7 regard to whether benefits are provided with respect to the event under any group health plan
8 maintained by the same plan sponsor:
9 (A) Coverage only for a specified disease or illness; or
10 (B) Hospital indemnity or other fixed indemnity insurance; and
11 (v) "Health insurance coverage" does not include the following if it is offered as a
12 separate policy, certificate, or contract of insurance:
13 (A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the
14 Social Security Act, 42 U.S.C. section 1395ss(g)(1);
15 (B) Coverage supplemental to the coverage provided under 10 U.S.C. section 1071 et
16 seq.; and
17 (C) Similar supplemental coverage provided to coverage under a group health plan;
18 (9) "Health status-related factor" means any of the following factors:
19 (i) Health status;
20 (ii) Medical condition, including both physical and mental illnesses;
21 (iii) Claims experience;
22 (iv) Receipt of health care;
23 (v) Medical history;
24 (vi) Genetic information;
25 (vii) Evidence of insurability, including conditions arising out of acts of domestic
26 violence; and
27 (viii) Disability;
28 (10) "Individual market" means the market for health insurance coverage offered to
29 individuals other than in connection with a group health plan;
30 (11) "Network plan" means health insurance coverage offered by a health insurance
31 carrier under which the financing and delivery of medical care including items and services paid
32 for as medical care are provided, in whole or in part, through a defined set of providers under
33 contract with the carrier; ~~and~~
34 (12) "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

(13) "High-risk individuals" means those individuals who do not pass medical underwriting standards.

SECTION 3. Section 27-18.6-12 of the General Laws in Chapter 27-18.6 entitled "Large Group Health Insurance Coverage" is hereby amended to read as follows:

27-18.6-12. Health plan loss information. -- (a) To ensure maximum competition in the purchase of group health insurance, all employers with ~~at least one hundred (100)~~ more than fifty (50) employees enrolled in their group health plan shall be entitled to receive their health plan loss information upon request and without charge. No contract between any health insurance carrier, third-party administrator, employer group, or pool of employers shall abridge this right in any manner. For purposes of this section, "health plan loss information" shall mean: (1) aggregate total cost figures for four (4) separate categories of medical claims covered by the employer's group health plan: physician, hospital, prescription drug, and miscellaneous; and (2) that were incurred for the twelve (12) month period paid through the fourteen (14) months which end within the sixty (60) day period prior to the date of the request. "Health plan loss information" shall not include any information: (1) pertaining to specific medical diagnoses, treatments or drugs; or (2) that identifies or reasonably could lead to the identity of any individuals covered under the group health plan; or (3) that is defined as protected or confidential health information under state or federal laws.

(b) Upon written request from any employer with ~~one hundred (100) or~~ than fifty (50) more employees enrolled in its group health plan, every health insurance carrier shall provide that employer's health plan loss information within thirty (30) calendar days of receipt of the request. An employer shall not be entitled by this section to more than two (2) health plan loss information requests in any twelve (12) month period, however, nothing shall prohibit a carrier from fulfilling more frequent requests on a mutually agreed upon basis.

(c) If an employer requests health plan loss information from an insurance agent or other authorized representative, the agent or authorized representative shall transmit the request to the health insurance carrier within four (4) working days.

SECTION 4. Section 27-19-2 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby amended to read as follows:

27-19-2. Organization as charitable corporation -- Insurance laws inapplicable. -- Each nonprofit hospital service corporation shall be incorporated as a charitable corporation under the provisions of chapter 6 of title 7, and shall be subject to that chapter and to this chapter. The laws of this state relative to insurance companies or to the business insurance shall not apply to any nonprofit hospital service corporation unless expressly provided in those laws. Each nonprofit hospital service corporation shall be deemed to be an insurer, for purposes of compliance in accordance with the provisions of chapter 44-17.

SECTION 5. Section 27-20-2 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby amended to read as follows:

27-20-2. Organization as charitable corporation -- Insurance laws inapplicable. -- Each nonprofit medical service corporation shall be incorporated as a charitable corporation under the provisions of chapter 6 of title 7, and shall be subject to that chapter and to this chapter. The laws of this state relative to insurance companies or to the business of insurance, and acts in amendment or in addition to those laws, shall not apply to any nonprofit medical service corporation unless expressly provided in those laws. Each nonprofit medical service corporation shall be deemed to be an insurer, for purposes of compliance in accordance with the provisions of chapter 44-17.

SECTION 6. Section 27-41-22 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby amended to read as follows:

27-41-22. Statutory construction and relationship to other laws. -- (a) Except as otherwise provided in this chapter, ~~provisions of the insurance law~~ and provisions of chapters 19, 20, 20.1, and 20.2 of this title shall not be applicable to any health maintenance organization granted a license under this chapter. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) Solicitation of enrollees by a health maintenance organization granted a license, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this chapter shall not be deemed to be practicing a profession, and may employ, or contract with, any licensed health professional to deliver professional services.

(d) No section of chapter 15 of title 23, the Health Care Certificate of Need Act, shall be abridged by this chapter.

1 (e) All information relating to a subscriber's health care history, diagnosis, condition,
2 treatment, or evaluation shall be considered confidential health care information and shall not be
3 released or transferred except under the safeguards established by chapter 37.3 of title 5, the
4 Confidentiality of Health Care Information Act.
5 (f) The provisions of chapter 19.1 of this title, relating to extended medical benefits, shall
6 be construed to apply to enrollees of health maintenance organizations.
7 (g) Any health maintenance organization authorized under this chapter shall be deemed to
8 be an insurer, for purposes of compliance in accordance with the provisions of chapter 44-17.
9 SECTION 7. Sections 27-50-3, 27-50-5, 27-50-7, 27-50-10 and 27-50-13 of the General
10 Laws in Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" are hereby
11 amended to read as follows:
12 **27-50-3. Definitions. --** (a) "Actuarial certification" means a written statement signed by
13 a member of the American Academy of Actuaries or other individual acceptable to the director
14 that a small employer carrier is in compliance with the provisions of section 27-50-5, based upon
15 the person's examination and including a review of the appropriate records and the actuarial
16 assumptions and methods used by the small employer carrier in establishing premium rates for
17 applicable health benefit plans.
18 (b) "Adjusted community rating" means a method used to develop a carrier's premium
19 which spreads financial risk across the carrier's entire small group population in accordance with
20 the requirements in section 27-50-5.
21 (c) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
22 through one or more intermediaries controls or is controlled by, or is under common control with,
23 a specified entity or person.
24 (d) "Affiliation period" means a period of time that must expire before health insurance
25 coverage provided by a carrier becomes effective, and during which the carrier is not required to
26 provide benefits.
27 (e) "Bona fide association" means, with respect to health benefit plans offered in this
28 state, an association which:
29 (1) Has been actively in existence for at least five (5) years;
30 (2) Has been formed and maintained in good faith for purposes other than obtaining
31 insurance;
32 (3) Does not condition membership in the association on any health-status related factor
33 relating to an individual (including an employee of an employer or a dependent of an employee);
34 (4) Makes health insurance coverage offered through the association available to all

1 members regardless of any health status-related factor relating to those members (or individuals
2 eligible for coverage through a member);
3 (5) Does not make health insurance coverage offered through the association available
4 other than in connection with a member of the association;
5 (6) Is composed of persons having a common interest or calling;
6 (7) Has a constitution and bylaws; and
7 (8) Meets any additional requirements that the director may prescribe by regulation.
8 (f) "Carrier" or "small employer carrier" means all entities licensed, or required to be
9 licensed, in this state that offer health benefit plans covering eligible employees of one or more
10 small employers pursuant to this chapter. For the purposes of this chapter, carrier includes an
11 insurance company, a nonprofit hospital or medical service corporation, a fraternal benefit
12 society, a health maintenance organization as defined in chapter 41 of this title or as defined in
13 chapter 62 of title 42, or any other entity providing a plan of health insurance or health benefits
14 subject to state insurance regulation.
15 (g) "Church plan" has the meaning given this term under section 3(33) of the Employee
16 Retirement Income Security Act of 1974 [29 U.S.C. section 1002(33)_.
17 (h) "Control" is defined in the same manner as in chapter 35 of this title.
18 (i) (1) "Creditable coverage" means, with respect to an individual, health benefits or
19 coverage provided under any of the following:
20 (i) A group health plan;
21 (ii) A health benefit plan;
22 (iii) Part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. section 1395c
23 et seq., or 42 U.S.C. section 1395j et seq., (Medicare);
24 (iv) Title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq., (Medicaid),
25 other than coverage consisting solely of benefits under 42 U.S.C. section 1396s (the program for
26 distribution of pediatric vaccines);
27 (v) 10 U.S.C. section 1071 et seq., (medical and dental care for members and certain
28 former members of the uniformed services, and for their dependents)(Civilian Health and
29 Medical Program of the Uniformed Services)(CHAMPUS). For purposes of 10 U.S.C. section
30 1071 et seq., "uniformed services" means the armed forces and the commissioned corps of the
31 national oceanic and atmospheric administration and of the public health service;
32 (vi) A medical care program of the Indian Health Service or of a tribal organization;
33 (vii) A state health benefits risk pool;
34 (viii) A health plan offered under 5 U.S.C. section 8901 et seq., (Federal Employees

1 Health Benefits Program (FEHBP));

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

5 (x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. section
6 2504(e)).

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

10 (j) "Dependent" means a spouse, an unmarried child under the age of nineteen (19) years,
11 an unmarried child who is a full-time student under the age of twenty-five (25) years and who is
12 financially dependent upon the parent, and an unmarried child of any age who is medically
13 certified as disabled and dependent upon the parent.

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

15 (l) "Economy health plan" means a lower cost health benefit plan developed pursuant to
16 the provisions of section 27-50-10.

17 (m) "Eligible employee" means an employee who works on a full-time basis with a
18 normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the
19 term shall also include an employee who works on a full-time basis with a normal work week of
20 anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this
21 eligibility criterion is applied uniformly among all of the employer's employees and without
22 regard to any health status-related factor. The term includes a self-employed individual, a sole
23 proprietor, a partner of a partnership, and may include an independent contractor, if the self-
24 employed individual, sole proprietor, partner, or independent contractor is included as an
25 employee under a health benefit plan of a small employer, but does not include an employee who
26 works on a temporary or substitute basis or who works less than seventeen and one-half (17.5)
27 hours per week. Any retiree under contract with any independently incorporated fire district is
28 also included in the definition of eligible employee. Persons covered under a health benefit plan
29 pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered
30 "eligible employees" for purposes of minimum participation requirements pursuant to section 27-
31 50-7(d)(9).

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

34 (o) "Established geographic service area" means a geographic area, as approved by the

1 director and based on the carrier's certificate of authority to transact insurance in this state, within
2 which the carrier is authorized to provide coverage.
3 (p) "Family composition" means:
4 (1) Enrollee;
5 (2) Enrollee, spouse and children;
6 (3) Enrollee and spouse; or
7 (4) Enrollee and children.
8 (q) "Genetic information" means information about genes, gene products, and inherited
9 characteristics that may derive from the individual or a family member. This includes information
10 regarding carrier status and information derived from laboratory tests that identify mutations in
11 specific genes or chromosomes, physical medical examinations, family histories, and direct
12 analysis of genes or chromosomes.
13 (r) "Governmental plan" has the meaning given the term under section 3(32) of the
14 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(32), and any federal
15 governmental plan.
16 (s) (1) "Group health plan" means an employee welfare benefit plan as defined in section
17 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the
18 extent that the plan provides medical care, as defined in subsection (y) of this section, and
19 including items and services paid for as medical care to employees or their dependents as defined
20 under the terms of the plan directly or through insurance, reimbursement, or otherwise.
21 (2) For purposes of this chapter:
22 (i) Any plan, fund, or program that would not be, but for PHSA Section 2721(e), 42
23 U.S.C. section 300gg(e), as added by P.L. 104-191, an employee welfare benefit plan and that is
24 established or maintained by a partnership, to the extent that the plan, fund or program provides
25 medical care, including items and services paid for as medical care, to present or former partners
26 in the partnership, or to their dependents, as defined under the terms of the plan, fund or program,
27 directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph
28 (ii) of this subdivision, as an employee welfare benefit plan that is a group health plan;
29 (ii) In the case of a group health plan, the term "employer" also includes the partnership
30 in relation to any partner; and
31 (iii) In the case of a group health plan, the term "participant" also includes an individual
32 who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary
33 who is, or may become, eligible to receive a benefit under the plan, if:
34 (A) In connection with a group health plan maintained by a partnership, the individual is

1 a partner in relation to the partnership; or

2 (B) In connection with a group health plan maintained by a self-employed individual, 3 under which one or more employees are participants, the individual is the self-employed 4 individual.

5 (t) (1) "Health benefit plan" means any hospital or medical policy or certificate, major 6 medical expense insurance, hospital or medical service corporation subscriber contract, or health 7 maintenance organization subscriber contract. Health benefit plan includes short-term and 8 catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as 9 otherwise specifically exempted in this definition.

10 (2) "Health benefit plan" does not include one or more, or any combination of, the 11 following:

12 (i) Coverage only for accident or disability income insurance, or any combination of 13 those;

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

15 (iii) Liability insurance, including general liability insurance and automobile liability 16 insurance;

17 (iv) Workers' compensation or similar insurance;

18 (v) Automobile medical payment insurance;

19 (vi) Credit-only insurance;

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

21 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant 22 to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other 23 insurance benefits.

24 (3) "Health benefit plan" does not include the following benefits if they are provided 25 under a separate policy, certificate, or contract of insurance or are otherwise not an integral part 26 of the plan:

27 (i) Limited scope dental or vision benefits;

28 (ii) Benefits for long-term care, nursing home care, home health care, community-based 29 care, or any combination of those; or

30 (iii) Other similar, limited benefits specified in federal regulations issued pursuant to 31 Pub. L. No. 104-191.

32 (4) "Health benefit plan" does not include the following benefits if the benefits are 33 provided under a separate policy, certificate or contract of insurance, there is no coordination 34 between the provision of the benefits and any exclusion of benefits under any group health plan

maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

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

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

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

(1) Health status;

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

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

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

(8) Disability.

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

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

(i) Who meets each of the following provisions:

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

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

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

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

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

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

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

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

(vii) Who meets the requirements for special enrollment pursuant to section 27-50-7 or

27-50-8.

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

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

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

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

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

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

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

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

(cc) (1) "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the enrollment date of the coverage.

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

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

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

1 (ff) "Rating period" means the calendar period for which premium rates established by a
2 small employer carrier are assumed to be in effect.
3 (gg) "Restricted network provision" means any provision of a health benefit plan that
4 conditions the payment of benefits, in whole or in part, on the use of health care providers that
5 have entered into a contractual arrangement with the carrier pursuant to provide health care
6 services to covered individuals.
7 (hh) "Risk adjustment mechanism" means the mechanism established pursuant to section
8 27-50-16.
9 (ii) "Self-employed individual" means an individual or sole proprietor who derives a
10 substantial portion of his or her income from a trade or business through which the individual or
11 sole proprietor has attempted to earn taxable income and for which he or she has filed the
12 appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.
13 (jj) "Significant break in coverage" means a period of ninety (90) consecutive days
14 during all of which the individual does not have any creditable coverage, except that neither a
15 waiting period nor an affiliation period is taken into account in determining a significant break in
16 coverage.
17 (kk) "Small employer" means, except for its use in section 27-50-7, any person, firm,
18 corporation, partnership, association, political subdivision, or self-employed individual that is
19 actively engaged in business including, but not limited to, a business or a corporation organized
20 under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of
21 another state that, on at least fifty percent (50%) of its working days during the preceding
22 calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week
23 of thirty (30) or more hours, the majority of whom were employed within this state, and is not
24 formed primarily for purposes of buying health insurance and in which a bona fide employer-
25 employee relationship exists. In determining the number of eligible employees, companies that
26 are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation
27 by this state, shall be considered one employer. Subsequent to the issuance of a health benefit
28 plan to a small employer and for the purpose of determining continued eligibility, the size of a
29 small employer shall be determined annually. Except as otherwise specifically provided,
30 provisions of this chapter that apply to a small employer shall continue to apply at least until the
31 plan anniversary following the date the small employer no longer meets the requirements of this
32 definition. The term small employer includes a self-employed individual.
33 (ll) "Standard health benefit plan" means a health benefit plan developed pursuant to
34 the provisions of section 27-50-10.

(mm) "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.

(nn) "Affordable health benefit plan" means a health benefit plan that is designed to promote health, i.e. disease prevention, wellness, disease management, preventive care, and/or similar health and wellness programs; that is actively marketed by a carrier in accordance with this chapter; and that may be modified or terminated by a carrier in accordance with section 27-50-6.

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

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; and

(iii) Family composition.

(2) A small employer carrier who as of June 1, 2000, varied rates by health status may vary the adjusted community rates for health status by ten percent (10%), provided that the resulting rates comply with the other requirements of this section, including subdivision (5) of this subsection.

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

(4) 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.

(5) For each health benefit plan offered by a carrier, the highest premium rate for each family composition type shall not exceed four (4) times the premium rate that could be charged to a small employer with the lowest premium rate for that family composition.

(6) 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 section 27-50-5.

(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 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. 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 section 27-18.6-2(20).

(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 director 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).

(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;

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

(4) 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.

(2) Each small employer carrier shall file with the director 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 director. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(3) A small employer carrier shall make the information and documentation described in subdivision (1) of this subsection available to the director 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 Select Care Rhode Island product, described in section 27-50-10, the rates proposed to be charged, the administrative practices expected to be used, and plan features to be offered by any carrier, shall be filed by the carrier at the office of the health insurance 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, the administrative practices expected to be used, and the plan features to be offered are consistent with the proper conduct of its business and with the interest of the public. The health insurance commissioner may approve,

disapprove, or modify the rates, administrative practices and/or plan features proposed to be offered by the carrier to achieve the objectives described in section 27-50-10 or any other regulation developed by the Commissioner.

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

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 section 27-50-3(kk).

(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 at least ~~two (2)~~ three (3) health benefit plans. One health benefit plan offered by each small employer carrier shall be a standard health benefit plan, ~~and~~ one plan shall be an economy health benefit plan, and one plan shall be Select Care Rhode Island, an affordable 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 or to any small employer renewing business with 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 small employer carrier shall file with the director, in a format and manner prescribed by the director, the health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this subdivision may be used by a small employer carrier beginning thirty (30) days after it is filed unless the director disapproves its use.

(2) The director may at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of

1 a health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

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

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

9 (2) (i) Except as provided in subdivision (3) of this subsection, a small employer carrier
10 shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of
11 creditable coverage without regard to the specific benefits covered during the period of creditable
12 coverage, provided that the last period of creditable coverage ended on a date not more than
13 ninety (90) days prior to the enrollment date of new coverage.

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

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

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

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

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

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

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

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

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

34 (B) Count a period of creditable coverage with respect to any class or category of

1 benefits if any level of benefits is covered within the class or category.

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

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

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

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

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

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

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

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

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

24 (7) (i) A small employer carrier shall permit an employee or a dependent of the
25 employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the group
26 health plan of the small employer during a special enrollment period if:

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

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

(C) The employee's or dependent's coverage described under subparagraph (A) of this paragraph:

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

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

(D) Under terms of the group health plan, the employee requests enrollment not later than thirty (30) days after the date of exhaustion of coverage described in item (C)(I) of this paragraph or termination of coverage or employer contribution described in item (C)(II) of this paragraph.

(ii) 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) A small employer carrier that makes coverage available under a group health plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in paragraph (ii) of this subdivision 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) 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) A person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

(ii) 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) The date dependent coverage is made available; or

(B) The date of the marriage, birth, or adoption or placement for adoption described in subparagraph (i)(B) of this subdivision.

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

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

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

(9) (i) 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) Except as provided in subsection (iii), herein 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:

(A) One hundred percent (100%) of eligible employees working for groups of ten (10) or less employees; and

(B) Seventy-five percent (75%) of eligible employees working for groups with more than ten (10) employees.

(iii) From October 1, 2004 until October 1, 2006, a small employer carrier shall not require a minimum participation level greater than seventy-five percent (75%) of eligible employees working for groups with ten (10) or less employees.

(iv) 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.

(v) 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) 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) 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.

1 (iii) Except as permitted under subdivisions (1) and (4) of this subsection, a small
2 employer carrier shall not modify a health benefit plan with respect to a small employer or any
3 eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude
4 coverage or benefits for specific diseases, medical conditions, or services covered by the plan.
5 (e) (1) Subject to subdivision (3) of this subsection, a small employer carrier is not
6 required to offer coverage or accept applications pursuant to subsection (b) of this section in the
7 case of the following:
8 (i) To a small employer, where the small employer does not have eligible individuals
9 who live, work, or reside in the established geographic service area for the network plan;
10 (ii) To an employee, when the employee does not live, work, or reside within the
11 carrier's established geographic service area; or
12 (iii) Within an area where the small employer carrier reasonably anticipates, and
13 demonstrates to the satisfaction of the director, that it will not have the capacity within its
14 established geographic service area to deliver services adequately to enrollees of any additional
15 groups because of its obligations to existing group policyholders and enrollees.
16 (2) A small employer carrier that cannot offer coverage pursuant to paragraph (1)(iii) of
17 this subsection may not offer coverage in the applicable area to new cases of employer groups
18 until the later of one hundred and eighty (180) days following each refusal or the date on which
19 the carrier notifies the director that it has regained capacity to deliver services to new employer
20 groups.
21 (3) A small employer carrier shall apply the provisions of this subsection uniformly to all
22 small employers without regard to the claims experience of a small employer and its employees
23 and their dependents or any health status-related factor relating to the employees and their
24 dependents.
25 (f) (1) A small employer carrier is not required to provide coverage to small employers
26 pursuant to subsection (b) of this section if:
27 (i) For any period of time the director determines the small employer carrier does not
28 have the financial reserves necessary to underwrite additional coverage; and
29 (ii) The small employer carrier is applying this subsection uniformly to all small
30 employers in the small group market in this state consistent with applicable state law and without
31 regard to the claims experience of a small employer and its employees and their dependents or
32 any health status-related factor relating to the employees and their dependents.
33 (2) A small employer carrier that denies coverage in accordance with subdivision (1) of
34 this subsection may not offer coverage in the small group market for the later of:

1 (i) A period of one hundred and eighty (180) days after the date the coverage is denied;
2 or
3 (ii) Until the small employer has demonstrated to the director that it has sufficient
4 financial reserves to underwrite additional coverage.
5 (g) (1) A small employer carrier is not required to provide coverage to small employers
6 pursuant to subsection (b) of this section if the small employer carrier elects not to offer new
7 coverage to small employers in this state.
8 (2) A small employer carrier that elects not to offer new coverage to small employers
9 under this subsection may be allowed, as determined by the director, to maintain its existing
10 policies in this state.
11 (3) A small employer carrier that elects not to offer new coverage to small employers
12 under subdivision (g)(1) shall provide at least one hundred and twenty (120) days notice of its
13 election to the director and is prohibited from writing new business in the small employer market
14 in this state for a period of five (5) years beginning on the date the carrier ceased offering new
15 coverage in this state.
16 **27-50-10. ~~Standard and economy health benefit plans.~~ Standard economy and Select**
17 **Care Rhode Island health benefit plans. --** (a) No provision contained in this chapter prohibits
18 the sale of health benefit plans which differ from the standard, ~~and~~ economy and Select Care
19 Rhode Island health benefit plans provided for in this section. The standard and economy health
20 benefit plans are exempted from the mandated benefits as provided for in section 27-50-13.
21 (b) (1) The standard health benefit plan shall include:
22 (i) Inpatient hospital care up to twenty (20) days per year;
23 (ii) Outpatient hospital care including, but not limited to, surgery and anesthesia,
24 preadmission testing, radiation therapy, and chemotherapy;
25 (iii) Emergency care through emergency room care and emergency admissions to a
26 hospital, excluding care for conditions that are not lifethreatening;
27 (iv) Pediatric care and well baby exams, with up to six (6) visits in a child's first year,
28 and childhood immunizations until age eight (8);
29 (v) Physician office visits or community health center visits for primary or sick care, up
30 to four (4) visits per year, and laboratory fees, surgery and anesthesia, diagnostic x-rays, and
31 physician care in a hospital inpatient or outpatient setting;
32 (vi) Maternity care including prenatal office visits, care in the hospital for mother, and
33 child and newborn nursery care;
34 (vii) Newborn metabolic and sickle cell screening, mammography, and pap tests;

1 (viii) Psychiatric care and substance abuse care up to twenty (20) outpatient visits per
2 year; inpatient psychiatric care and inpatient substance abuse care shall be included in the twenty
3 (20) days provided by paragraph (i) of this subdivision. The lifetime substance abuse benefit is a
4 maximum of forty-five (45) inpatient days; and
5 (ix) Home nursing care in lieu of or to reduce hospital length of stay, up to twenty (20)
6 visits per year.
7 (2) The term "physician" includes doctors of medicine, osteopathy, and optometry.
8 (3) Standard health care benefits include the following copayments:
9 (i) A twenty percent (20%) copayment will be charged for all services except for
10 inpatient hospitalization;
11 (ii) A two hundred dollar ($200) per day copayment will be charged for each day of
12 inpatient hospitalization in any acute care hospital or psychiatric care or substance abuse care
13 treatment facility;
14 (iii) A twenty percent (20%) copayment will be charged for any covered emergency
15 room visit, except that when a patient is admitted to the hospital as an inpatient, the copayment
16 shall be waived; and
17 (iv) There shall be an annual out of pocket stop loss of two thousand five hundred dollars
18 ($2,500) per individual and five thousand dollars ($5,000) per family. After the stop loss amount
19 has been reached, no additional copayments shall be charged until the beginning of the next
20 contract year.
21 (4) Cost containment mechanisms may be used for all services to include, but not be
22 limited to, the following:
23 (i) Primary care gatekeepers;
24 (ii) Preadmission certification;
25 (iii) Mandatory second opinion prior to elective surgery;
26 (iv) Preauthorization for specified services;
27 (v) Concurrent utilization review and management;
28 (vi) Discharge planning for hospital care;
29 (vii) Design and implementation of a structure of copayments as described in this
30 chapter; and
31 (viii) Less costly alternatives to inpatient care.
32 (c) (1) The economy health benefit plan shall include:
33 (i) Inpatient hospital care up to twenty (20) days per year;
34 (ii) Outpatient hospital care including, but not limited to, surgery and anesthesia,

preadmission testing, radiation therapy, and chemotherapy;

(iii) Emergency care through emergency room care and emergency admissions to a hospital excluding care for conditions that are not life threatening;

(iv) Pediatric care and well baby exams, with up to six (6) visits in a child's first year, and childhood immunizations until age eight (8);

(v) Physician office visits or community health center visits for primary or sick care, up to four (4) visits per year, and laboratory fees, surgery and anesthesia, diagnostic x-rays, and physician care in a hospital inpatient or outpatient setting;

(vi) Maternity care including prenatal office visits, care in the hospital for mother and child, and newborn nursery care;

(vii) Newborn metabolic and sickle cell screening, mammography, and pap tests;

(viii) Psychiatric care and substance abuse care up to twenty (20) outpatient visits per year; inpatient psychiatric care and inpatient substance abuse care shall be included in the twenty (20) days provided by paragraph (i) of this subdivision. The lifetime substance abuse benefit shall be a maximum of forty-five (45) inpatient days; and

(ix) Home nursing care in lieu of or to reduce hospital length of stay, up to twenty (20) visits per year.

(2) The term "physician" includes doctors of medicine, osteopathy, and optometry;

(3) Economy health care benefits include the following copayments:

(i) A twenty percent (20%) copayment shall be charged for any covered service contained in paragraphs (1)(iv), (1)(vi), (1)(vii), and (1)(ix) of this subsection;

(ii) A three hundred dollar ($300) per day copayment will be charged for each day of inpatient hospitalization in any acute care hospital or psychiatric care or substance abuse care treatment facility;

(iii) A fifty percent (50%) copayment shall be charged for any covered service contained in paragraphs (1)(ii), (1)(iii), (1)(v), and (1)(viii) of this subsection, except that when a patient is admitted to the hospital from the emergency room, the copayment shall be waived; and

(iv) There shall be an annual out of pocket stop loss of two thousand five hundred dollars ($2,500) per individual and five thousand dollars ($5,000) per family. After the stop loss amount has been reached, no additional copayments shall be charged until the beginning of the next contract year.

(4) Cost containment mechanisms may be used for all services to include, but not be limited to, the following:

(i) Primary care gatekeepers;

(ii) Preadmission certification;

(iii) Mandatory second opinion prior to elective surgery;

(iv) Preauthorization for specified services;

(v) Concurrent utilization review and management;

(vi) Discharge planning for hospital care;

(vii) Design and implementation of a structure of copayments as described in this chapter; and

(viii) Less costly alternatives to inpatient care.

(d) [Deleted by P.L. 2003, ch. 120, section 1 and by P.L. 2003, ch. 286, section 1.]

(e) The Select Care Rhode Island benefit plan shall be established by the health insurance commissioner through regulation. The health insurance commissioner shall develop all aspects of the Select Care Rhode Island plan including, but not limited to, benefit levels, cost–sharing levels, exclusions and limitations. The plan may also include cost containment features including, but not limited to, those specified in subsections (b)(4) and (c)(4) of this section. The primary objective of Select Care Rhode Island is to provide an affordable product, that creates appropriate incentives for employers, providers, health plans and consumers to, among other things:

(1) focus on primary care, prevention and wellness;

(2) encourage the use of the most cost effective setting;

(3) encourage identification and management of high-risk/high-cost conditions; and

(4) protect small businesses and their employees from the costs of catastrophic illness while still maintaining affordability. The plan shall be made available as required by regulation.

27-50-13. Waiver of certain state laws. -- No law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization, or inclusion of a specific category of licensed health care practitioner, applies to an economy ~~or~~, standard or the Select Care Rhode Island health benefit plan delivered or issued for delivery to small employers in this state pursuant to this chapter. Notwithstanding the foregoing, the benefits for mastectomy treatment mandated in sections 27-18-39, 27-19-34 and 27-41-43 and the benefits mandated by federal law in 42 USC 300gg-4, 29 USC 1185, 42 USC 300gg-5, 29 USC 1185a, 42 USC 300gg-6, 29 USC 1185b shall be added to the benefits in section 27-50-10 for ~~both~~ the standard ~~and~~, economy and Select Health Care Rhode Island health benefit plans.

SECTION 8. Section 36-12-6 of the General Laws in Chapter 36-12 entitled "Insurance Benefits" is hereby amended to read as follows:

36-12-6. Authority to purchase group life, accidental death, long-term health care,

<u>and other insurance benefits. --</u> (a) The director of administration, or any employee of the department of administration designated by the director as his or her agent, is hereby authorized, empowered, and directed to contract with one or more insurance companies duly licensed by this state for the purchase of one or more contracts providing for group life, accidental death, long term health care and other insurance benefits in conformity with the provisions of sections 36-12-6 -- 36-12-14, to purchase contracts of insurance and to administer all provisions of sections 36-12-6 -- 36-12-14. Before entering into any insurance contract under this chapter, the director shall invite proposals from such qualified insurers as in his or her opinion would desire to accept any part of the insurance coverage authorized by sections 36-12-6 -- 36-12-14 including hospital care and surgical-medical services with the specific condition that the benefits and services provided by the carrier(s) will be substantially equivalent to those set forth in any collective bargaining agreements executed between the state of Rhode Island and authorized representatives of the unions representing state employees or the health care coverage presently being provided.

(b) The state will work diligently with leadership of organized labor in order to ensure competitiveness, cost effective health care services for all employees of the state who may be eligible for those benefits.

(c) Any new plan must accept pre-existing conditions for those individuals who will be covered by the new policy.

(d) The director may arrange with the company or companies from which the policy or policies of insurance authorized herein are purchased to reinsure portions of any contract or contracts of insurance with other insurance companies duly licensed in this state which elect to enter into contracts of reinsurance and are legally competent to do so. The director may annually redetermine the amount or amounts of coverage to be allocated to reinsuring companies in advance of any contract year after the first year.

(e) The director may designate one or more of those insurance companies as the administering company or companies.

(f) Each employee who is covered under any contract or contracts shall receive a certificate setting forth the benefits to which the employee and his or her dependents are entitled thereunder, to whom benefits shall be payable, to whom claims should be submitted, and summarizing the provisions of the contract principally affecting the employee and his or her dependents.

(g) The director may, on June 30, 1961, or at the end of any fiscal year thereafter, discontinue any insurance contract or contracts he or she has purchased from any corporation or corporations and replace it or them with a contract or contracts in any other corporation or

corporations meeting the requirements of sections 36-12-6 -- 36-12-14.

(h) The director of administration shall not consider proposals nor purchase insurance contracts to administer the provisions of section 36-12-6 through 36-12-14 from any carrier, as defined in section 27-50-3, unless the carrier participates in the Select Care Market Incentive Program, as described in section 27-50-17.

SECTION 9. Section 42-12.3-10 of the General Laws in Chapter 42-12.3 entitled "Health Care for Children and Pregnant Women" is hereby amended to read as follows:

42-12.3-10. Administration. -- The department of human services may cooperate through interagency cooperative agreements, with the department of health and/or other state agencies, and any other agreements they deem necessary, to assure that health care services for eligible pregnant women and children under the age of eighteen (18) are provided in an efficient and timely basis. The department of human services shall not consider proposals nor purchase insurance contracts to administer the programs described in sections 42-12.3-3 or 42-12.3-4, from any carrier, as defined in section 27-50-3, unless the carrier participates in the Select Care Market Incentive Program, as described in section 27-50-17. The department of human services shall monitor and evaluate the medical services and health outcomes of clients served by the RIte Track and RIte Start programs. The department of human services shall be responsible for assuring marketing, enrollee relations, quality assurance, provider recruitment, and network development. The department is hereby authorized to promulgate any and all necessary rules and regulations to carry out the intent of this chapter.

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

42-14.5-3. Powers and duties. [Contingent effective date; see notes under section 42-14.5-1.] -- The health insurance commissioner shall have the following powers and duties:

(a) To conduct an annual public meeting or meetings, separate and distinct from rate hearings pursuant to section 42-62-13, regarding the rates, services and operations of insurers licensed to provide health insurance in the state the effects of such rates, services and operations on consumers, medical care providers and patients, and the market environment in which such insurers operate. Notice of not less than ten (10) days of said hearing(s) shall go to the general assembly, the governor, the Rhode Island medical society, the Hospital Association of Rhode Island, the director of health, and the attorney general. Public notice shall be posted on the department's web site and given in the newspaper of general circulation, and to any entity in writing requesting notice.

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

(c) To establish a consumer/business/labor/medical advisory council to obtain information and present concerns of consumers, business and medical providers affected by health insurance decisions. The council shall be involved in the planning and conduct of the public meeting in accordance with subsection (a) above. The advisory council shall assist in the design of an insurance complaint process to ensure that small businesses whom experience extraordinary rate increases in a given year could request and receive a formal review by the department. The advisory council shall assess views of the health provider community relative to insurance rates of reimbursement, billing and reimbursement procedures, and the insurers' role in promoting efficient and high quality health care. The advisory council shall issue an annual report of findings and recommendations to the governor and the joint legislative committee on health care oversight. The advisory council is to be diverse in interests and shall include representatives of community consumer organizations; small businesses, other than those involved in the sale of insurance products; and hospital, medical, and other health provider organizations. Such representatives shall be nominated by their respective organizations. The advisory council shall be co-chaired by the health insurance commissioner and a community consumer organization or small business member to be elected by the full advisory council.

(d) To establish and provide guidance and assistance to a subcommittee ("The Professional Provider-Health Plan Work Group") of the advisory council created pursuant to subsection (c) above, composed of health care providers and Rhode Island licensed health plans. This subcommittee shall develop a plan to implement the following activities:

(i) By January 1, 2006, a method whereby health plans shall disclose to contracted providers the fee schedules used to provide payment to those providers for services rendered to covered patients;

(ii) By April 1, 2006, a standardized provider application and credentials verification process, for the purpose of verifying professional qualifications of participating health care providers;

(iii) By September 1, 2006, a uniform health plan claim form to be utilized by participating providers;

(iv) By December 1, 2006, contractual disclosure to participating providers of the mechanisms for resolving health plan/provider disputes; and

(v) By February 1, 2007, a uniform process for confirming in real time patient insurance enrollment status, benefits coverage, including co-pays and deductibles.

A report on the work of the subcommittee shall be submitted by the health insurance commissioner to the joint legislative committee on health care oversight on March 1, 2006 and March 1, 2007.

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

(f) There is created within the general fund a restricted receipt account to be known as the "Select Care Market Incentive Account". All money in the account shall be utilized by the health insurance commissioner to effectuate the provisions of sections 27-18.5-9 and 27-50-17. Funding priority will be given to section 27-18.5-9, the Select Care Direct Market Incentive Program, with any remaining balance allocated toward section 27-50-17, the Select Care Market Incentive Program for Business. The annual taxes collected from health maintenance organizations, as defined in chapter 27-41, and nonprofit hospital and medical service corporations, as defined in sections 27-19 and 27-20, as authorized in section 44-17 shall be deposited in the Select Care Market Incentive Account. The general treasurer is authorized and directed to draw his or her orders on the account upon receipt of properly authenticated vouchers from the health insurance commissioner. Administrative resources to manage the account will be provided by the account, not to exceed two (2%) percent of the total account, including appropriation of up to three (3) state employed FTE as needed.

SECTION 11. Sections 44-17-1 and 44-17-2 of the General Laws in Chapter 44-17 entitled "Taxation of Insurance Companies" are hereby amended to read as follows:

44-17-1. Companies required to file -- Payment of tax -- Retaliatory rates. -- Every domestic, foreign, or alien insurance company, mutual association, organization, or other insurer, including, without limitation, a health maintenance organization, as defined in section 27-41-1, a nonprofit hospital or medical service corporation, as defined in chapters 27-19 and 27-20, except companies mentioned in section 44-17-6, and organizations defined in section 27-25-1, transacting business in this state, shall, on or before March 1 in each year, file with the tax

administrator, in the form that he or she may prescribe, a return under oath or affirmation signed by a duly authorized officer or agent of the company, containing information that may be deemed necessary for the determination of the tax imposed by this chapter, and shall at the same time pay an annual tax to the tax administrator of two percent (2%) of the gross premiums on contracts of insurance, except:

(a) insurers subject to chapters 27-19 and 27-20 shall pay the lesser of the following:

(1) one percent (1%) of the gross premiums on contracts of insurance; or

(2) up to one hundred percent (100%) of the difference between the insurer's reported medical loss ratio and eighty-eight percent (88%) medical loss ratio, as determined by the health insurance commissioner. If the reported medical loss ratio of the insurers, subject to the provisions of chapter 27-19 and 27-20, is greater than or equal to eighty-eight percent (88%) such insurers tax liability will be zero.

(b) health maintenance organizations, as defined in section 27-41-1, shall pay the lesser of the following:

(1) two percent (2%) of the gross premiums on contracts of insurance; or

(2) up to one hundred percent (100%) of the difference between the insurer's reported medical loss ratio and eighty-eight percent (88%) medical loss ratio, as determined by the health insurance commissioner. If the reported medical loss ratio of the health maintenance organization is greater than or equal to eighty-eight percent (88%) the tax liability will be zero.

(c) ocean marine insurance, as referred to in section 44-17-6, covering property and risks within the state, written during the calendar year ending December 31st next preceding, but in the case of foreign or alien companies, except as provided in section 27-2-17(d) the tax is not less in amount than is imposed by the laws of the state or country under which the companies are organized upon like companies incorporated in this state or upon its agents, if doing business to the same extent in the state or country.

44-17-2. Amounts included as gross premiums. -- Gross premiums include all premiums and premium deposits and assessments on all policies, certificates, and renewals, written during the year, covering property and risks within the state, policies subsequently cancelled, and reinsurance assumed, whether the premiums and premium deposits and assessments are in the form of money, notes, credits, or other substitute for money, after deducting from the gross premiums the amount of return premiums on the contracts covering property and risks within this state and the amount of premiums for reinsurance assumed, of the property and risks. Mutual companies and companies which transact business on the mutual plan are also allowed to deduct from their premiums and premium deposits and assessments, the so-

1 called dividends or unused or unabsorbed portion of the premiums and premium deposits and
2 assessments applied in part payment of the premiums and premium deposits and assessments or
3 returned to policyholders in cash or credited to policy holders during the year for which the tax is
4 computed. Every domestic company, mutual association, organization, or other insurer, shall
5 include for taxation in like manner and with like deductions premiums and premium deposits and
6 assessments written, procured, or received in this state on business covering property or risks in
7 any other state on which the company has not paid and is not liable to pay a tax to the other state.
8 In those cases where the premium tax collected may be based on the reported medical loss ratio,
9 such as is described in section 44-17-1, the calculation will be based on two (2) years prior
10 premiums and medical costs as reported to the health insurance commissioner and the health
11 insurance commissioner shall provide the data and perform the calculation in support of the
12 department of taxation.
13 SECTION 12. Chapter 27-18.5 of the General Laws entitled "Individual Health Insurance
14 Coverage" is hereby amended by adding thereto the following sections:
15 **27-18.5-8. Select Care Direct. –** The "Select Care Direct" benefit plan shall be
16 established by the health insurance commissioner through regulation. The health insurance
17 commissioner shall develop all aspects of the Select Care Direct plan, including, but not limited
18 to, benefit levels, cost-sharing levels, exclusions and limitations. The plan may also include cost
19 containment features, including, but not limited to, those specified in subsections (b)(4) and (c)(4)
20 of section 27-50-10.
21 (a) The primary objective of Select Care Direct is to provide an affordable product that
22 creates appropriate incentives for providers, health plans and consumers, including, but not
23 limited to, the following:
24 (i) focus on primary care, prevention and wellness;
25 (ii) encourage the use of the most cost-effective setting;
26 (iii) encourage identification and management of high-risk/high-cost conditions; and
27 (iv) protect individuals from the cost of catastrophic illness while still maintaining
28 affordability. The plan shall be made available as required by regulation.
29 (b) The Select Care Direct benefit plan is exempted from state mandated benefits. No
30 law requiring the coverage of a health care service or benefit, or requiring the reimbursement,
31 utilization, or inclusion of a specific category of licensed health care practitioner, applies to the
32 Select Care Direct health benefit plan delivered or issued for delivery to individuals in this state
33 pursuant to this chapter. Notwithstanding the foregoing, the benefits for mastectomy treatment
34 mandated in sections 27-18-39, 27-19-34 and 27-41-43, and the benefits by federal law in 42

USC 300gg-51 and 42 USC 300gg-52 shall be added to the benefits mandated for the Select Direct health benefit plan.

(c) All carriers that offer health insurance in the individual market shall actively market and offer the Select Care Direct benefit plan to eligible individuals.

27-18.5-9. Select Care Direct Market Incentive Program. – The health insurance commissioner shall allocate funds from the Select Care Market Incentive Account, described in section 42-14.5-3, toward the Select Care Direct Market Incentive Program.

(a) The purpose of this program is threefold:

(1) to encourage individuals to choose the Select Care Direct benefit plan, an affordable plan design which begins to address the underlying cost of care in Rhode Island through appropriate incentives for employers, and consumers and providers;

(2) to specifically assist high-cost/high-risk individuals with the escalating cost of health insurance premiums; and

(3) to address the inequitable and unsustainable financial burden on not-for-profit insurers in the indiv idual market.

(b) The Select Care Direct Market Incentive Program will apply solely to high risk individuals who purchase the Select Care Direct benefit plan.

(c) The Select Care Direct Market Incentive Program will be in the form of an insurer risk/share arrangement, which encourages insurers to offer the lowest possible premium rate to participating individuals by sharing in the losses within a prescribed corridor of risk. The specific structure of the insurer risk share arrangement will be defined by regulations promulgated by the health insurance commissioner. The maximum protection will, in no event, exceed the amount available in the account.

(d) Individual market carriers will be eligible to participate in the Select Care Direct Market Incentive Program only if the following two (2) conditions are met:

(1) The carrier has participated in the individual market for at least one year; and

(2) The carrier covers at least four thousand (4,000) members in the individual market.

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

27-50-12.1. Renewal rating. – To ensure ease of understanding of renewal rate calculations and related information, the health insurance commissioner may, by regulation, prescribe uniform procedures and presentation formats for delivery of renewal rates to small employers.

27-50-17. Select Care Market incentive Program for Business. – The health insurance

1 commissioner shall allocate funds from the Select Care Market Incentive Account, described in
2 section 42-14.5-3, toward the Select Care Market Incentive Program for Business.
3 (a) The purpose of this program is twofold:
4 (1) to encourage employers to choose the Select Care Rhode Island benefit plan, an
5 affordable plan design which begins to address the underlying cost of care in Rhode Island
6 through appropriate incentives for employers, consumers and providers;
7 (2) to specifically encourage low wage employers to offer health insurance.
8 (b) The Select Care Market Incentive Program for Business will apply solely to the Select
9 Care Rhode Island benefit plan, described in section 27-50-10. Eligible employers include low
10 wage firms, as defined in section 27-50-3, who pay a minimum of twenty-five (25%) percent of
11 single coverage premium. At least one such low wage worker must be enrolled in the program.
12 Eligibility will be determined based on quarterly tax filings. The program will cover all
13 employees of eligible firms.
14 (c) The Select Care Market Incentive Program for Business will be in the form of an
15 insurer risk-share arrangement, which encourages insurers to offer the lowest possible premium
16 rate to participating employees by sharing in the losses within a prescribed corridor of risk. The
17 specific structure of the insurer risk share arrangement will be defined by regulation promulgated
18 by the health insurance commissioner. The maximum protection will in no event exceed the
19 amount available in the account.
20 (d) All carriers, as defined in section 27-50-3, who participate in the Rhode Island RIte
21 Care program, as defined in section 42-12.3-4 and the procurement process for the Rhode Island
22 state employee account, as described in chapter 36-12, must participate in the Select Care Market
23 Incentive Program.
24 SECTION 14. Title 27 of the General Laws entitled "INSURANCE" is hereby amended
25 by adding thereto the following chapter:
26 CHAPTER 70
27 HEALTH INSURANCE AFFORDABILITY AND TRANSPARENCY
28 **27-70-1. Short title. –** This chapter shall be known and may be cited as "The Health
29 Insurance Affordability and Transparency Act of 2006".
30 **27-70-2. Legislative purpose. –** The purpose of this chapter is to provide consumers with
31 access to information about out-of-pocket costs for which they would be responsible under health
32 insurance for which they are covered.
33 **27-70-3. Definitions. –** As used in this chapter:
34 (1) "Clinical laboratory" means an entity licensed by the department under R23-16.2-

1 C&S/LAB.

2 (2) "Coinsurance" means a percentage of the health plan's negotiated rate for a health care
3 service or supply for which an individual's responsible for paying under the terms of his or her
4 policy with a health plan covered under this chapter.

5 (3) "Commissioner" means the health insurance commissioner.

6 (4) "Control of radiation facility" means an entity licensed by the department of health
7 under R23-1.3-RAD. Such an entity does not include a:

8 (i) Hospital;

9 (ii) Rehabilitation hospital center;

10 (iii) Freestanding ambulatory surgical center;

11 (iv) Physician ambulatory surgical center; and

12 (v) Podiatry ambulatory surgical center.

13 (5) "Deductible" means an amount that a covered individual must pay before a carrier
14 begins reimbursing for eligible expenses.

15 (6) "Freestanding ambulatory surgical center" means an entity licensed by the department
16 of health under R23-17-OACF.

17 (7) "Health care entity" means an entity subject to the provisions of sections 27-18, 27-
18 19, 27-20, or 27-41 of the general laws.

19 (8) "Health plan" means a plan operated by a health care entity that provides for the
20 delivery of care services to person enrolled in the plan through:

21 (i) Arrangements with selected providers to furnish health care services; and/or

22 (ii) Financial incentives for persons enrolled in the plan to use the participating providers
23 and procedures provided for by the plan.

24 (9) "Hospital" means an entity licensed by the department of health under R23-17-HOSP.

25 (10) Physician ambulatory surgical center" or "podiatry ambulatory surgical center"
26 mean an entity licensed by the department of health under R23-17-PASC.

27 (11) "Prices paid" means the amount upon which the coinsurance and/or deductible is
28 based.

29 (12) "Provider" mans a physician, hospital, pharmacy, laboratory, dentist, or other state
30 licensed or other state recognized provider of health care services or supplies, and whose services
31 are recognized pursuant to the Internal Revenue Code, 26 U.S.C. section 213(d), that has entered
32 into an agreement with a health care entity to provide these services or supplies to a patient
33 enrolled in a plan.

34 (13) "Rehabilitation hospital center" means an entity licensed by the department of health

under R23-17-REHAB.27-69-3.

27-70-4. Information disclosure requirements. – (a) On or before January 1, 2007, a health plan subject to this chapter shall disclose to enrollees the negotiated amounts the health plan pays to providers for services, procedures, tests, drugs, or supplies that are subject to a deductible and/or coinsurance. There shall be two (2) methods for such disclosures, a general disclosure and a specific disclosure.

(b) In its general disclosure, a health plan shall make certain information available to enrollees in an Internet accessible, consumer-friendly manner to assist enrollees in making an informed choice about where to obtain their health care services. Health plans shall also provide such information in a hard copy form at no charge to enrollees, upon their request. The general disclosure shall, at a minimum, include the following information:

(i) The prices paid, by type or category of service, for every hospital and rehabilitation hospital center to which the health plan makes payment.

(ii) The prices paid for the fifty (50) most frequently performed procedures by every hospital's outpatient department, freestanding ambulatory surgical centers, physician ambulatory surgical centers, and podiatry ambulatory surgical centers to which health plan makes payment.

(iii) The prices paid for the twenty-five (25) most frequently performed radiological or radioisotopic diagnostic test or procedures by every hospitals and control of radiation facility, to which health plan makes payment.

(iv) The prices paid for the fifty (50) most frequently performed tests by a clinical laboratory, whether in a hospital, a freestanding facility, or in any other setting, to which health plan makes payment.

(v) For prescription drugs, information no less than required of Medicare Prescription Drug Plans and Medicare Advantage Plans under the Medicare Prescription Drug Improvement and Modernization Act of 2003 (P.L. 108-173).

(c) By January, 2009, the director shall evaluate the efficacy of these general disclosure requirements and shall issue regulations governing general disclosures. Those regulations may impose different and/or greater general disclosure requirements on health plans than established by these provisions.

(d) A health plan's specific disclosures shall be made by telephone in response to a telephonic request. A health plan subject to these provisions shall make available a toll-free customer service telephone line to provide answers to enrollees about the out-of-pocket costs, to enrollees for any services, procedures, tests, drugs, or supplies offered by any provider that will be subject to deductibles and/or coinsurance and to assist enrollees to determine the specific cost

1 of such services, procedures, tests, drugs or supplies to the enrollee if obtained from a specific
2 provider.
3 **27-70-5. Penalties and enforcement. –** (a) An administrative penalty may be levied in
4 accordance with section 42-14-16, if reasonable notice, in writing, is given of the intent to levy
5 the penalty and the particular health care entity has a reasonable time in which to remedy the
6 defect in its operations which gave rise to the penalty citation.
7 (b) Any person who knowingly and willfully violates this chapter shall be guilty of a
8 misdemeanor and may be punished by a fine not to exceed five hundred dollars ($500) or by
9 imprisonment for a period not exceeding one year, or both.
10 (c) If the commissioner shall for any reason have cause to believe that any violation of
11 this chapter has occurred or is threatened, the commissioner may give notice to the particular
12 health care entity and to their representatives, or other persons who appear to be involved in the
13 suspected violation, to arrange a conference with the alleged violators or their authorized
14 representative for the purpose of attempting to ascertain the facts relating to the suspected
15 violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at
16 an adequate and effective means of correcting or preventing the violation;
17 (d) Proceedings under this subsection shall be governed by chapter 35 of title 42.
18 (e) The commissioner may issue an order directing a particular health care entity or a
19 representative of that health care entity to cease and desist from engaging in any act or practice in
20 violation of the provisions of this chapter;
21 (f) Within thirty (30) days after service of the order to cease and desist, the respondent
22 may request a hearing on the question of whether acts or practices in violation of this chapter
23 have occurred. Those hearing shall be conducted pursuant to sections 42-35-9 through 42-35-13,
24 and judicial review shall be available as provided by sections 42-35-15 and 42-35-16.
25 (g) In the case of any violation of the provisions of this chapter, if the commissioner
26 elects not to issue a cease and desist order, or in the event of noncompliance with a cease and
27 desist order issued by the commissioner, the commissioner may institute a proceeding to obtain
28 injunctive relief, or seeking other appropriate relief, in the superior court for the county of
29 Providence.
30 SECTION 15. Chapter 44-17 of the General Laws entitled "Taxation of Insurance
31 Companies" is hereby amended by adding thereto the following section:
32 **44-17-12. Select Care Market Incentive Account. –** The annual taxes collected from
33 health maintenance organizations, as defined by chapter 27-41, and nonprofit hospital and
34 medical service corporations, as defined by chapter 27-19 and 27-20, as authorized in section 44-

1 17-1 shall be deposited in the Select Care Market Incentive Account, as described in section 42-

2 14.5-3.

3 SECTION 16. Severability. If any provision of this act or the application thereof to any

4 person or circumstance is held invalid, such invalidity shall not affect other provisions or

5 applications of the act, which can be given effect without the invalid provision or application, and

6 to this end the provisions of this act are declared to be severable.

7 SECTION 17. This act shall take effect on January 1, 2007.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N   A C T

RELATING TO HEALTH AND SAFETY - HEALTH INSURANCE AFFORDABILITY AND TRANSPARENCY ACT OF 2006

***

1 This act would establish "Select Care", an affordable health plan for both the individual
2 and small group markets. It would further establish the "Select Care Market Incentive Program",
3 an insurer risk share arrangement to subsidize the Select Care product and would mandate that
4 insurers provide consumer price information for both employers and members to allow for cost-
5 effective decision-making.
6 This act would take effect on January 1, 2007.

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