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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. 2012

A N A C T

RELATING TO INSURANCE -- HEALTH INSURANCE - CONSUMER PROTECTION

Introduced By: Senator Rhoda E. Perry

Date Introduced: April 12, 2012

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Purpose and intent.

It is the purpose of this act to amend Rhode Island statutes so as to be consistent with health insurance consumer protections enacted in federal law. This act is intended to establish health insurance rules, standards, and policies pursuant to, in furtherance of, and in addition to the health insurance standards established in the Patient Protection and Affordable Care Act of 2010, as amended by the Health care and Education Reconciliation Act of 2010.

SECTION 2. Chapter 27-18 of the General laws entitled "Accident and Sickness Insurance Policies" is hereby amended by adding thereto the following section:

27-18-1-1. Definitions. – As used in this chapter:

(1) “Adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan or to receive coverage under a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The term also includes a rescission of coverage determination.

(2) ‘Affordable Care Act’ means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

(3) “Commissioner” or “health insurance commissioner” means that individual appointed pursuant to section 42-14.5-1 of the general laws.

(4) “Grandfathered health plan” means any group health plan or health insurance coverage subject to 42 USC section 18011.

(5) “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(6) “Group health plan” means an employee welfare benefit plan, as defined in 29 USC section 1002(1), to the extent that the plan provides health benefits to employees or their dependents directly or through insurance, reimbursement, or otherwise.

(7) “Health benefits” or “covered benefits” means medical, surgical, hospital, prescription drug, and such other benefits, whether self-funded, or delivered through the purchase of insurance or otherwise.

(8) “Health care facility” means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(9) “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(10) “Health care provider” or "provider" means a health care professional or a health care facility.

(11) “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

(12) “Health insurance carrier” means a person, firm, corporation or other entity subject to the jurisdiction of the commissioner under this chapter. Such term does not include a group health plan.

(13) “Health plan” or “health benefit plan” means health insurance coverage and a group health plan, including coverage provided through an association plan if it covers Rhode Island residents. Except to the extent specifically provided by the Affordable Care Act, the term “health plan” shall not include a group health plan to the extent state regulation of the health plan is pre-empted under section 514 of the Employee Retirement Income Security Act of 1974. The term

also shall not include:

(A)(i) Coverage only for accident, or disability income insurance, or any combination thereof.

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

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

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, the health insurance portability and accountability act of 1996 ("HIPAA"), under which benefits for medical care are secondary or incidental to other insurance benefits.

(B) The following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Other excepted benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191 ("HIPAA").

(C) The following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

(ii) Hospital indemnity or other fixed indemnity insurance.

(D) The following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplement health insurance as defined under section 1882(g)(1) of the Social Security Act.

(ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

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

(14) "Office of the health insurance commissioner" means the agency established under

section 42-14.5-1 of the General laws.

(15) “Rescission" means a cancellation or discontinuance of coverage that has retroactive effect for reasons unrelated to timely payment of required premiums or contribution to costs of coverage.

27-18-2.1. Uniform explanation of benefits and coverage. – (a) A health insurance carrier shall provide a uniform summary of benefits and coverage explanation and standardized definitions to policyholders and others required by, and at the times required, by the federal regulations adopted under section 2715 of the Affordable Care Act. A summary required by this section shall be filed with the commissioner for approval under Rhode Island general laws section 27-18-8 et seq. The requirements of this section shall be in addition to the requirements of Rhode Island general laws section 27-18-8 et seq. The commissioner may waive one or more of the requirements of the regulations adopted under section 2715 of the Affordable Care Act for good cause shown. The summary must contain at least the following information:

(1) Uniform definitions of standard insurance and medical terms.

(2) A description of coverage and cost sharing for each category of essential benefits and other benefits.

(3) Exceptions, reductions and limitations in coverage.

(4) Renewability and continuation of coverage provisions.

(5) A “coverage facts label” that illustrates coverage under common benefits scenarios.

(6) A statement of whether the policy, contract or plan provides the minimum coverage required of a qualified health plan.

(7) A statement that the outline is a summary and that the actual policy language should be consulted; and

(8) A contact number for the consumer to call with additional questions and the web address of where the actual language of the policy, contract or plan can be found.

(b) The provisions of this section shall apply to grandfathered health plans.

27-18-78. Prohibition on rescission of coverage. – (a)(1) Coverage under a health benefit plan subject to the jurisdiction of the commissioner under this chapter with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, shall not be rescinded after the individual is covered under the plan, unless:

(A) The individual or a person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud; or

(B) The individual makes an intentional misrepresentation of material fact, as prohibited

by the terms of the plan or coverage.

(2) For purposes of paragraph (a)(1)(A), a person seeking coverage on behalf of an individual does not include an insurance producer or employee or authorized representative of the health carrier.

(b) At least thirty (30) days advance written notice shall be provided to each health benefit plan enrollee or, for individual health insurance coverage, primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection (a) regardless of, in the case of group health insurance coverage, whether the rescission applies to the entire group or only to an individual within the group.

(c) For purposes of this section, "to rescind" means to cancel or to discontinue coverage with retroactive effect for reasons unrelated to timely payment of required premiums or contribution to costs of coverage.

(d) This section applies to grandfathered health plans.

27-18-79. Prohibition on annual and lifetime limits. – (a) Annual limits.

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

(A) For a plan or policy year beginning after September 22, 2010, but before September 23, 2011 – seven hundred fifty thousand dollars ($750,000);

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

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

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

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

(B) The provisions of this subsection shall not prevent a health insurance carrier and a health benefit plan from placing annual dollar limits for any individual on specific covered

benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal law or the laws and regulations of this state.

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

(b) Lifetime limits.

(1)A health insurance carrier and health benefit plan offering group or individual health insurance coverage shall not establish a lifetime limit on the dollar value of essential health benefits, as designated pursuant to a state determination and in accordance with federal laws and regulations, for any individual.

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

(c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this subsection, this subsection applies to any individual:

(A) Whose coverage or benefits under a health plan ended by reason of reaching a lifetime limit on the dollar value of all benefits for the individual; and

(B) Who, due to the provisions of this section, becomes eligible, or is required to become eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the health benefit plan:

(i) For group health insurance coverage, on the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, on the first day of the first policy year beginning on or after September 23, 2010.

(2) For individual health insurance coverage, an individual is not entitled to reinstatement under the health benefit plan under this subsection if the individual reached his or her lifetime limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection applies to a family member who reached his or her lifetime limit in a family plan and other family members remain covered under the plan.

(3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to become eligible for benefits, the health insurance carrier and health benefit plan shall provide the individual written notice that:

(i) The lifetime limit on the dollar value of all benefits no longer applies; and

(ii) The individual, if still covered under the plan, is again eligible to receive benefits under the plan.

(B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for, but not enrolled in any benefit package under the plan, the health insurance carrier and health benefit plan shall provide an opportunity for the individual to enroll in the plan for a period of at least thirty (30) days.

(C) The notices and enrollment opportunity under this subdivision shall be provided beginning not later than:

(i) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010;

(ii) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010; or

(iii) The notices required under this subsection shall be provided:

(I) For group health insurance coverage, to an employee on behalf of the employee's dependent; or

(II) For individual health insurance coverage, to the primary subscriber on behalf of the primary subscriber's dependent.

(D) For group health insurance coverage, the notices may be included with other enrollment materials that a health plan distributes to employees, provided the statement is prominent. For group health insurance coverage, if a notice satisfying the requirements of this subsection is provided to an individual, a health insurance carrier's requirement to provide the notice with respect to that individual is satisfied.

(E) For any individual who enrolls in a health plan in accordance with subdivision (2) of this subsection, coverage under the plan shall take effect not later than:

(i) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

(d)(1) An individual enrolling in a health plan for group health insurance coverage in accordance with subsection (c) above shall be treated as if the individual were a special enrollee as provided under regulations interpreting the HIPAA portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

(2) An individual enrolling in accordance with subsection (c) above:

(A) Shall be offered all of the benefit packages available to similarly situated individuals

who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value of all benefits; and

(B) Shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

(3) For purposes of subsection (B)(1), any difference in benefits or cost-sharing constitutes a different benefit package.

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

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

27-18-80. Coverage for preventive items and services. – (a) Every health insurance carrier providing coverage under an individual or group health plan shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(1) Except as otherwise provided in subsection (b) of this section, and except as may otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010 and as may subsequently be amended.

(2) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

(3) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(4) With respect to women, to the extent not described in subdivision (1) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive coverage guidelines supported by the Health Resources and Services Administration.

(b)(1) A health insurance carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection (a) of this section after the recommendation or guideline is no longer described in subsection (a) of this section. The provisions of this subdivision shall not affect the obligation of the health insurance carrier to provide notice to a covered person before any material modification of coverage becomes effective, in accordance with other requirements of state and federal law, including section 2715(d)(4) of the Public Health Services Act.

(2) A health insurance carrier shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

(c)(1) A health insurance carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is billed separately or is tracked as individual encounter data separately from the office visit.

(2) A health insurance carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service described in subsection (a) of this section.

(3) A health insurance carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

(d)(1) Nothing in this section requires a health insurance carrier that has a network of providers to providing coverage for items and services described in subsection (a) of this section that are delivered by an out-of-network provider.

(2) Nothing in subsection (a) of this section precludes a health insurance carrier that has a network of providers from imposing cost-sharing requirements for items or services described in

subsection (a) of this section that are delivered by an out-of-network provider.

(e) Nothing prevents a health insurance carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in subsection (a) of this section to the extent not specified in the recommendation or guideline.

(f) Nothing in this section prohibits a health insurance carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health insurance carrier may impose cost-sharing requirements for a treatment not described in subsection (a) of this section even if the treatment results from an item or service described in subsection (a) of this section.

(g) This section shall not apply to grandfathered health plans.

27-18-81. Coverage for individuals participating in approved clinical trials. – (a) As used in this section,

(1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a life-threatening disease or condition and is described in any of the following:

(A) The study or investigation is approved or funded, which may include funding through in-kind contributions, by one or more of the following:

(i) The National Institutes of Health;

(ii) The Centers for Disease Control and Prevention;

(iii) The Agency for Health Care Research and Quality;

(iv) The Centers for Medicare & Medicaid Services;

(v) A cooperative group or center of any of the entities described in items (i) through (iv) or the Department of Defense or the Department of Veteran Affairs;

(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(vii) A study or investigation conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of U.S. Department of Health and Human Services determines:

(I) Is comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(II) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

(2) "Participant" has the meaning stated in section 3(7) of ERISA.

(3) "Participating provider" means a health care provider that, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

(4) "Qualified individual" means a participant or beneficiary who meets the following conditions:

(A) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition; and

(B)(i) The referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate based on the individual meeting the conditions described in subdivision (A) of this subdivision (3); or

(ii) The participant or beneficiary provides medical and scientific information establishing the individual's participation in such trial would be appropriate based on the individual meeting the conditions described in subdivision (A) of this subdivision (3).

(5) "Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(b)(1) If a health insurance carrier offering group or individual health insurance coverage provides coverage to a qualified individual, the health insurance carrier:

(A) Shall not deny the individual participation in an approved clinical trial.

(B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the approved clinical trial; and

(C) Shall not discriminate against the individual on the basis of the individual's participation in the approved clinical trial.

(2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all items and services consistent with the coverage typically covered for a qualified individual who is not enrolled in an approved clinical trial.

(B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not include:

(i) The investigational item, device or service itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(3) If one or more participating providers are participating in a clinical trial, nothing in subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection shall apply to a qualified individual participating in an approved clinical trial that is conducted outside this state.

(5) This section shall not be construed to require a health insurance carrier offering group or individual health insurance coverage to provide benefits for routine patient care services provided outside of the coverage's health care provider network unless out-of-network benefits are otherwise provided under the coverage.

(6) Nothing in this section shall be construed to limit a health insurance carrier's coverage with respect to clinical trials.

(c) The requirements of this section shall be in addition to the requirements of Rhode Island general laws sections 27-18-36 through 27-18-36.3.

(d) This section shall not apply to grandfathered health plans.

(e) This section shall be effective for plan years beginning on or after January 1, 2014.

27-18-82. Medical loss ratio rebates. – (a) A health insurance carrier offering group or individual health insurance coverage, including a grandfathered health plan, shall pay medical loss ratio rebates as provided for in Section 2718(b)(1)(A) of the Affordable Care Act, in the manner and as required by federal laws and regulations.

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

27-18-83. Emergency services. – (a) As used in this section:

(1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) Placing the health of the individual, or with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part

(2) "Emergency services" means, with respect to an emergency medical condition:

(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

(3) "Stabilize", with respect to an emergency medical condition has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) If a health insurance carrier offering health insurance coverage provides any benefits with respect to services in an emergency department of a hospital, the carrier must cover emergency services in compliance with this section.

(c) A health insurance carrier shall provide coverage for emergency services in the following manner:

(1) Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

(2) Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services;

(3) If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers;

(4) If the emergency services are provided out of network, by complying with the cost-sharing requirements of subsection (d) of this section; and

(5) Without regard to any other term or condition of the coverage, other than:

(A) The exclusion of or coordination of benefits;

(B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or

(C) Applicable cost-sharing.

(d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network; provided, however, that a participant or beneficiary may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the health insurance carrier is required to pay under subdivision (1) of this subsection. A health insurance carrier complies with the requirements of this subsection if it provides benefits with respect to an emergency service in an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision (1)(which are adjusted for in-network cost-sharing requirements).

(A) The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. If there is more than one amount negotiated with in-network providers for the emergency service, the amount described under this subdivision (A) is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. In determining the median described in the preceding sentence, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount under this subdivision (A) is disregarded.

(B) The amount for the emergency service shall be calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is determined without reduction for out-of-network cost-sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services.

(C) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary.

(2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency

services provided out of network if the cost-sharing requirement generally applies to out-of-network benefits. A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-network emergency services.

(e) The provisions of this section apply for plan years beginning on or after September 23, 2010.

(f) This section shall not apply to grandfathered health plans.

27-18-84. Internal and external appeal of adverse benefit determinations. – (a) The commissioner shall adopt regulations to implement standards and procedures with respect to internal claims and appeals of adverse benefit determinations, and with respect to external appeals of adverse benefit determinations.

(b) The regulations adopted by the commissioner shall apply to those adverse benefit determinations within the jurisdiction of the commissioner.

SECTION 3. Sections 27-18-8, 27-18-44 and 27-18-59 of the General laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" are hereby amended to read as follows:

27-18-8. Filing of accident and sickness insurance policy forms. -- Any insurance company authorized to do an accident and sickness business within this state in accordance with the provisions of this title shall file all accident and sickness insurance policy forms and rates used by it in the state with the insurance commissioner, including the forms of any rider, endorsement, application blank, and other matter generally used or incorporated by reference in its policies or contracts of insurance. No such rate shall be used unless first approved by the commissioner. No such form shall be used if disapproved by the commissioner under this section, or if the commissioner's approval has been withdrawn under section 27-18-8.3, or until the expiration of the waiting period established under section 27-18-8.3. Such a company shall comply with its filed and approved rates and forms. If the commissioner finds from an examination of any form that it is contrary to the public interest, or the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the company in writing as provided in section 27-18-8.2. Each form shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance with applicable laws and that the benefits are reasonable in relation to the premium to be charged.

27-18-44. Primary and preventive obstetric and gynecological care. – (a) Any insurer or health plan, nonprofit health medical service plan, or nonprofit hospital service plan that provides coverage for obstetric and gynecological care for issuance or delivery in the state to any

group or individual on an expense-incurred basis, including a health plan offered or issued by a health insurance carrier or a health maintenance organization, shall permit a woman to receive an annual visit to an in-network obstetrician/gynecologist for routine gynecological care without requiring the woman to first obtain a referral from a primary care provider.

(b)(1)(A) Any health plan, nonprofit medical service plan or nonprofit hospital service plan, including a health insurance carrier or a health maintenance organization which requires or provides for the designation by a covered person of a participating primary health care professional shall permit each covered person to:

(i) Designate any participating primary care health care professional who is available to accept the covered person; and

(ii) For a child, designate any participating physician who specializes in pediatrics as the child's primary care health care professional and is available to accept the child.

(2) The provisions of subdivision (1) of this subsection shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

(c)(1) If a health plan, nonprofit medical service plan or nonprofit hospital service plan, including a health insurance carrier or a health maintenance organization, provides coverage for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, then it:

(A) Shall not require any person's, including a primary care health care professional's, prior authorization or referral in the case of a female covered person who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology; and

(B) Shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to subdivision (A) of this subdivision (c)(1), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care health care professional.

(2)(A) A health plan, nonprofit medical service plan or nonprofit hospital service plan, including a health insurance carrier or a health maintenance organization may require the health care professional to agree to otherwise adhere to its policies and procedures, including procedures relating to referrals, obtaining prior authorization, and providing services in accordance with a treatment plan, if any, approved by the plan, carrier or health maintenance organization.

(B)For purposes of subdivision (A) of this subdivision (c)(1), a health care professional, who specializes in obstetrics or gynecology, means any individual, including an individual other

than a physician, who is authorized under state law to provide obstetrical or gynecological care.

(3) The provisions of subdivision (A) of this subdivision (c)(1) shall not be construed to:

(A) Waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care; or

(B) Preclude the health plan, nonprofit medical service plan or nonprofit hospital service plan, including a health insurance carrier or a health maintenance organization involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the plan, carrier or health maintenance organization of treatment decisions.

(d) Notice Requirements:

(1) A health plan, nonprofit medical service plan or nonprofit hospital service plan, including a health insurance carrier or a health maintenance organization subject to this section shall provide notice to covered persons of the terms and conditions of the plan related to the designation of a participating health care professional and of a covered person’s rights with respect to those provisions.

(2)(A) In the case of group health insurance coverage, the notice described in subdivision (1) of this subsection shall be included whenever the a participant is provided with a summary plan description or other similar description of benefits under the health benefit plan.

(B) In the case of individual health insurance coverage, the notice described in subdivision (1) of this subsection shall be included whenever the primary subscriber is provided with a policy, certificate or contract of health insurance.

(C) A health plan, nonprofit medical service plan or nonprofit hospital service plan, including a health insurance carrier or a health maintenance organization, may use the model language in 45 CFR section 147.138(a)(4)(iii) to satisfy the requirements of this subsection.

(e) The requirements of subsections (b), (c), and (d) shall not apply to grandfathered health plans.

27-18-59. ~~Termination of children's benefits~~ Eligibility for children's benefits. -- (a)(1) Every individual health insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state and every group health insurance contract, plan, or policy delivered, issued for delivery or renewed in this state which provides ~~medical~~ health benefits coverage for ~~dependent children that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage~~ dependents, except for supplemental policies which only provide coverage for specified diseases and other supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried child under the age~~

~~of nineteen (19) years, an unmarried child who is a student under the age of twenty-five (25) years and who is financially dependent upon the parent and an unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months~~ for children until attainment of twenty-six (26) years of age. ~~Such contract, plan or policy shall also include a provision that policyholders shall receive no less than thirty (30) days notice from the accident and sickness insurer that a child covered as a dependent by the policy holder is about to lose his or her coverage as a result of reaching the maximum age for a dependent child, and that the child will only continue to be covered upon documentation being provided of current full or part-time enrollment in a post-secondary educational institution or that the child may purchase a conversion policy if he or she is not an eligible student. Nothing in this section prohibits an accident and sickness insurer from requiring a policyholder to annually provide proof of a child's current full or part-time enrollment in a post-secondary educational institution in order to maintain the child's coverage. Provided, nothing in this section requires coverage inconsistent with the membership criteria in effect under the policyholder's health benefits coverage.~~

(2) With respect to a child who has not attained twenty-six (26) years of age, a health insurance carrier shall not define “dependent” for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the plan participant, and, in the individual market, primary subscriber.

(3) A health insurance carrier shall not deny or restrict coverage for a child who has not attained twenty-six (26) years of age based on the presence or absence of the child’s financial dependency upon the participant, primary subscriber or any other person, residency with the participant and in the individual market the primary subscriber, or with any other person, marital status, student status, employment or any combination of those factors. A health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage, except as provided in subparagraph (d)(1) of this section.

(4) Nothing in this section shall be construed to require a health insurance carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

(5) The terms of coverage in a health benefit plan offered by a health insurance carrier providing dependent coverage of children cannot vary based on age except for children who are twenty-six (26) years of age or older.

(b)(1) This subsection applies to any child:

(A) Whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage of a child ended before the attainment of twenty-six (26) years of age; and

(B) Who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010 by reason of the provisions of this section.

(2)(A) If group health insurance coverage or individual health insurance coverage, in which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in which the child's coverage ended or did not begin for the reasons described in subdivision (1) of this subsection, and if the health insurance carrier is subject to the requirements of this section the health insurance carrier shall give the child an opportunity to enroll that continues for at least sixty (60) days, including the written notice of the opportunity to enroll as described subdivision (3) of this subsection.

(B) The health insurance carrier shall provide the opportunity to enroll, including the written notice beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.

(3)(A) The written notice of opportunity to enroll shall include a statement that children whose coverage ended, or who were denied coverage, or were not eligible for coverage, because the availability of dependent coverage of children ended before the attainment of twenty-six (26) years of age are eligible to enroll in the coverage.

(B)(i) The notice may be provided to an employee on behalf of the employee's child and, in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

(ii) For group health insurance coverage:

(I)The notice may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent; and

(II) If a notice satisfying the requirements of this subdivision is provided to an employee whose child is entitled to an enrollment opportunity under subsection (c) of this section, the obligation to provide the notice of enrollment opportunity under subdivision (B) of this subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.

(C) The written notice shall be provided beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.

(4) For an individual who enrolls under this subsection, the coverage shall take effect not

later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

(c)(1) A child enrolling in group health insurance coverage pursuant to subsections (b) and (c) of this section shall be treated as if the child were a special enrollee, as provided under regulations interpreting the Health Insurance Portability and Accountability Act ("HIPAA") portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

(2)(A) The child and, if the child would not be a participant once enrolled, the participant through whom the child is otherwise eligible for coverage under the plan, shall be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(B) For purposes of this subdivision (2), any difference in benefits or cost-sharing requirements constitutes a different benefit package.

(3) The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(d)(1) For plan years beginning before January 1, 2014, a health insurance carrier providing group health insurance coverage that is a grandfathered health plan and makes available dependent coverage of children may exclude an adult child who has not attained twenty-six (26) years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

(2) For plan years, beginning on or after January 1, 2014, a health insurance carrier providing group health insurance coverage that is a grandfathered health plan shall comply with the requirements of subsections (a) through (e) of this section.

(3) The provisions of this section shall apply to policy years in the individual market on and after September 23, 2010.

~~(b)~~(e) This section does not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other limited benefit policies.

SECTION 4. Sections 27-19-1 and 27-19-50 of the General laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" are hereby amended to read as follows:

27-19-1. Definitions. -- As used in this chapter:

(1) "Contracting hospital" means an eligible hospital which has contracted with a nonprofit hospital service corporation to render hospital care to subscribers to the nonprofit

hospital service plan operated by the corporation;

(2) Adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan or to receive coverage under a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The term also includes a rescission of coverage determination.

(3) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

(4) “Commissioner” or “health insurance commissioner” means that individual appointed pursuant to section 42-14.5-1 of the General laws.

(5) "Eligible hospital" is one which is maintained either by the state or by any of its political subdivisions or by a corporation organized for hospital purposes under the laws of this state or of any other state or of the United States, which is designated as an eligible hospital by a majority of the directors of the nonprofit hospital service corporation;

(6) “Grandfathered health plan” means any group health plan or health insurance coverage subject to 42 USC section 18011;

(7) “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan;

(8) “Group health plan” means an employee welfare benefit plan as defined 29 USC section 1002(1), to the extent that the plan provides health benefits to employees or their dependents directly or through insurance, reimbursement, or otherwise;

(9) “Health benefits” or “covered benefits” means medical, surgical, hospital, prescription drug, and such other benefits, whether self-funded, or delivered through the purchase of insurance or otherwise;

(10) “Health care facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(11) "Health care professional" means a physician or other health care practitioner

licensed, accredited or certified to perform specified health care services consistent with state law;

(12) "Health care provider" or "provider" means a health care professional or a health care facility;

(13) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

(14) “Health insurance carrier” means a person, firm, corporation or other entity subject to the jurisdiction of the commissioner under this chapter, and includes nonprofit hospital service corporations. Such term does not include a group health plan;

(15) "Health plan" or "health benefit plan" means health insurance coverage and a group health plan, including coverage provided through an association plan if it covers Rhode Island residents. Except to the extent specifically provided by the Affordable Care Act, the term “health plan” shall not include a group health plan to the extent state regulation of the health plan is pre-empted under section 514 of the Employee Retirement Income Security Act of 1974. The term also shall not include:

(A)(i) Coverage only for accident, or disability income insurance, or any combination thereof.

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

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

(iv) Workers’ compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, the health insurance portability and accountability act of 1996 (“HIPAA”), under which benefits for medical care are secondary or incidental to other insurance benefits.

(B) The following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii)Other excepted benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191 (“HIPAA”).

(C) The following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

(ii) Hospital indemnity or other fixed indemnity insurance.

(D) The following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplement health insurance as defined under section 1882(g)(1) of the Social Security Act.

(ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

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

~~(3)~~(16) "Nonprofit hospital service corporation" means any corporation organized pursuant to this chapter for the purpose of establishing, maintaining, and operating a nonprofit hospital service plan;

~~(4)~~(17) "Nonprofit hospital service plan" means a plan by which specified hospital care is to be provided to subscribers to the plan by a contracting hospital; ~~and~~

(18) "Office of the health insurance commissioner" means the agency established under section 42-14.5-1 of the General Law;

(19) “Rescission" means a cancellation or discontinuance of coverage that has retroactive effect for reasons unrelated to timely payment of required premiums or contribution to costs of coverage; and

~~(5)~~(20) "Subscribers" mean those persons, whether or not residents of this state, who have contracted with a nonprofit hospital service corporation for hospital care pursuant to a nonprofit hospital service plan operated by the corporation.

27-19-50. ~~Termination of children's benefits~~ Eligibility for children's benefits. -- (a) (1) Every individual health insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state and every group health insurance contract, plan, or policy delivered, issued for delivery or renewed in this state which provides ~~medical~~ health benefits coverage ~~for dependent children that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage~~ dependents, except for supplemental policies which only provide coverage for specified diseases and other supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried child under the age~~

~~of nineteen (19) years, an unmarried child who is a student under the age of twenty-five (25) years and who is financially dependent upon the parent and an unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months~~ for children until attainment of twenty-six (26) years of age. ~~Such contract, plan or policy shall also include a provision that policyholders shall receive no less than thirty (30) days notice from the nonprofit hospital service corporation that a child covered as a dependent by the policyholder is about to lose his or her coverage as a result of reaching the maximum age for a dependent child and that the child will only continue to be covered upon documentation being provided of current full or part-time enrollment in a post-secondary educational institution, or that the child may purchase a conversion policy if he or she is not an eligible student.~~

~~(b) Nothing in this section prohibits a nonprofit hospital service corporation from requiring a policyholder to annually provide proof of a child's current full or part-time enrollment in a post-secondary educational institution in order to maintain the child's coverage. Provided, nothing in this section requires coverage inconsistent with the membership criteria in effect under the policyholder's health benefits coverage.~~

(2) With respect to a child who has not attained twenty-six (26) years of age, a health insurance carrier shall not define “dependent” for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the plan participant, and, in the individual market, primary subscriber.

(3) A health insurance carrier shall not deny or restrict coverage for a child who has not attained twenty-six (26) years of age based on the presence or absence of the child’s financial dependency upon the participant, primary subscriber or any other person, residency with the participant and in the individual market the primary subscriber, or with any other person, marital status, student status, employment or any combination of those factors. A health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage, except as provided in (d)(1) of this section.

(4) Nothing in this section shall be construed to require a health insurance carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

(5) The terms of coverage in a health benefit plan offered by a health insurance carrier providing dependent coverage of children cannot vary based on age except for children who are twenty-six (26) years of age or older.

(b)(1) This subsection applies to any child:

(A) Whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage of a child ended before the attainment of twenty-six (26) years of age; and

(B) Who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010 by reason of the provisions of this section.

(2)(A) If group health insurance coverage or individual health insurance coverage, in which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in which the child's coverage ended or did not begin for the reasons described in subdivision (1) of this subsection, and if the health insurance carrier is subject to the requirements of this section the health insurance carrier shall give the child an opportunity to enroll that continues for at least sixty (60) days, including the written notice of the opportunity to enroll as described subdivision (3) of this subsection.

(B) The health insurance carrier shall provide the opportunity to enroll, including the written notice beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.

(3)(A) The written notice of opportunity to enroll shall include a statement that children whose coverage ended, or who were denied coverage, or were not eligible for coverage, because the availability of dependent coverage of children ended before the attainment of twenty-six (26) years of age are eligible to enroll in the coverage.

(B)(i) The notice may be provided to an employee on behalf of the employee's child and, in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

(ii) For group health insurance coverage:

(I) The notice may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent; and

(II) If a notice satisfying the requirements of this subdivision is provided to an employee whose child is entitled to an enrollment opportunity under subsection (b) of this section, the obligation to provide the notice of enrollment opportunity under subdivision (B) of this subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.

(C) The written notice shall be provided beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.

(4) For an individual who enrolls under this subsection, the coverage shall take effect not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

(c)(1) A child enrolling in group health insurance coverage pursuant to subsection (b) of this section shall be treated as if the child were a special enrollee, as provided under regulations interpreting the HIPAA portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

(2)(A) The child and, if the child would not be a participant once enrolled, the participant through whom the child is otherwise eligible for coverage under the plan, shall be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(B) For purposes of this subdivision (2), any difference in benefits or cost-sharing requirements constitutes a different benefit package.

(3) The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(d)(1) For plan years beginning before January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered health plan and makes available dependent coverage of children may exclude an adult child who has not attained twenty-six (26) years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

(2) For plan years, beginning on or after January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered health plan shall comply with the requirements of subsections (a) through (e).

(3) The provision of this section applies to policy years in the individual market on and after September 23, 2010, and shall apply to grandfathered health plans.

~~(b)~~(e) This section does not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other limited benefit policies.

SECTION 5. Chapter 27-19 of the General laws entitled "Nonprofit Hospital Service Corporations" is hereby amended by adding thereto the following sections:

27-19-7.1. Uniform explanation of benefits and coverage. – (a) A nonprofit hospital service corporation shall provide a uniform summary of benefits and coverage explanation and

standardized definitions to policyholders and others required by, and at the times required by, the federal regulations adopted under section 2715 of the Affordable Care Act. A summary required by this section shall be filed with the commissioner for approval under Rhode Island general laws section 27-19-7.2. The requirements of this section shall be in addition to the requirements of Rhode Island general laws section 27-19-7.2. The commissioner may waive one or more of the requirements of the regulations adopted under section 2715 of the Affordable Care Act for good cause shown. The summary must contain at least the following information:

(1) Uniform definitions of standard insurance and medical terms.

(2) A description of coverage and cost-sharing for each category of essential benefits and other benefits.

(3) Exceptions, reductions and limitations in coverage.

(4) Renewability and continuation of coverage provisions.

(5) A “coverage facts label” that illustrates coverage under common benefits scenarios.

(6) A statement of whether the policy, contract or plan provides the minimum coverage required of a qualified health plan.

(7) A statement that the outline is a summary and that the actual policy language should be consulted; and

(8) A contact number for the consumer to call with additional questions and the web address of where the actual language of the policy, contract or plan can be found.

(b) The provisions of this section shall apply to grandfathered health plans.

27-19-7.2. Filing of policy forms. – A nonprofit hospital service corporation shall file all policy forms and rates used by it in the state with the commissioner, including the forms of any rider, endorsement, application blank, and other matter generally used or incorporated by reference in its policies or contracts of insurance. No such rate shall be used unless first approved by the commissioner. No such form shall be used if disapproved by the commissioner under this section, or if the commissioner's approval has been withdrawn after notice and an opportunity to be heard, or until the expiration of sixty (60) days following the filing of the form. A nonprofit hospital service corporation shall comply with its filed and approved rates and forms. If the commissioner finds from an examination of any form that it is contrary to the public interest, or the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the corporation in writing. Each form shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance with applicable laws and that the benefits are reasonable in relation to the premium to be charged.

27-19-62. Prohibition on rescission of coverage. – (a)(1) Coverage under a health plan

subject to the jurisdiction of the commissioner under this chapter with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, shall not be rescinded after the individual is covered under the plan, unless:

(A) The individual or a person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud; or

(B) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

(2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an individual does not include an insurance producer or employee or authorized representative of the health carrier.

(b) At least thirty (30) days advance written notice shall be provided to each health benefit plan enrollee or, for individual health insurance coverage, primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection (a) regardless of, in the case of group health insurance coverage, whether the rescission applies to the entire group or only to an individual within the group.

(c) For purposes of this section, "to rescind" means to cancel or to discontinue coverage with retroactive effect for reasons unrelated to timely payment of required premiums or contribution to costs of coverage.

(d) This section applies to grandfathered health plans.

27-19-63. Prohibition on annual and lifetime limits. – (a) Annual limits. (1) For plan or policy years beginning prior to January 1, 2014, for any individual, a health insurance carrier and health benefit plan subject to the jurisdiction of the commissioner under this chapter may establish an annual limit on the dollar amount of benefits that are essential health benefits provided the restricted annual limit is not less than the following:

(A) For a plan or policy year beginning after September 22, 2010, but before September 23, 2011 – seven hundred fifty thousand dollars ($750,000);

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

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

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

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

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

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

(b) Lifetime limits.

(1) A health insurance carrier and health benefit plan offering group or individual health insurance coverage shall not establish a lifetime limit on-the-dollar-value of essential health benefits, as designated pursuant to a state determination and in accordance with federal laws and regulations, for any individual.

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

(c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this subsection, this subsection applies to any individual:

(A) Whose coverage or benefits under a health plan ended by reason of reaching a lifetime limit on the dollar value of all benefits for the individual; and

(B) Who, due to the provisions of this section, becomes eligible, or is required to become eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the health benefit plan:

(i) For group health insurance coverage, on the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, on the first day of the first policy year beginning on or after September 23, 2010.

(2) For individual health insurance coverage, an individual is not entitled to reinstatement under the health benefit plan under this subsection if the individual reached his or her lifetime limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection

applies to a family member who reached his or her lifetime limit in a family plan and other family members remain covered under the plan.

(3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to become eligible for benefits under the health benefit plan, the health carrier shall provide the individual written notice that:

(i) The lifetime limit on the dollar value of all benefits no longer applies; and

(ii) The individual, if still covered under the plan, is again eligible to receive benefits under the plan.

(B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for, but not enrolled in any benefit package under the plan, the health benefit plan shall provide an opportunity for the individual to enroll in the plan for a period of at least thirty (30) days.

(C) The notices and enrollment opportunity under this subdivision shall be provided beginning not later:

(i) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

(iii) The notices required under this subsection shall be provided:

(I)For group health insurance coverage, to an employee on behalf of the employee's dependent; or

(II) For individual health insurance coverage, to the primary subscriber on behalf of the primary subscriber's dependent.

(D) For group health insurance coverage, the notices may be included with other enrollment materials that a health plan distributes to employees, provided the statement is prominent. For group health insurance coverage, if a notice satisfying the requirements of this subsection is provided to an individual, a health insurance carrier's requirement to provide the notice with respect to that individual is satisfied.

(E) For any individual who enrolls in a health plan in accordance with subdivision (2) of this subsection, coverage under the plan shall take effect not later than:

(i) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

(d)(1) An individual enrolling in a health plan for group health insurance coverage in

accordance with subsection (c) of this subsection shall be treated as if the individual were a special enrollee in the plan, as provided under regulations interpreting the HIPAA portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

(2) An individual enrolling in accordance with subsection (c) of this subsection:

(A) shall be offered all of the benefit packages available to similarly situated individuals who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value of all benefits; and

(B) Shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

(3) For purposes of subsection B(1), any difference in benefits or cost-sharing constitutes a different benefit package.

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

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

27-19-64. Coverage for preventive items and services. – (a) Every health insurance carrier providing coverage under an individual or group health plan shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(1) Except as otherwise provided in subsection (b) of this section, and except as may otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010, and as may subsequently be amended.

(2) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered

to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

(3) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(4) With respect to women, to the extent not described in subdivision (1) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive coverage guidelines supported by the Health Resources and Services Administration.

(b)(1) A health insurance carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection (a) of this section after the recommendation or guideline is no longer described in subsection (a) of this section. The provisions of this subdivision shall not affect the obligation of the health insurance carrier to provide notice to a covered person before any material modification of coverage becomes effective, in accordance with other requirements of state and federal law, including section 2715(d)(4) of the Public Health Services Act.

(2) A health insurance carrier shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

(c)(1) A health insurance carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is billed separately or is tracked as individual encounter data separately from the office visit.

(2) A health insurance carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service described in subsection (a) of this section.

(3) A health insurance carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

(d)(1) Nothing in this section requires a health insurance carrier that has a network of providers to provide coverage for items and services described in subsection (a) of this section that are delivered by an out-of-network provider.

(2) Nothing in subsection (a) of this section precludes a health insurance carrier that has a network of providers from imposing cost-sharing requirements for items or services described in subsection (a) of this section that are delivered by an out-of-network provider.

(e) Nothing prevents a health insurance carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in subsection (a) of this section to the extent not specified in the recommendation or guideline.

(f) Nothing in this section prohibits a health insurance carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health insurance carrier may impose cost-sharing requirements for a treatment not described in subsection (a) of this section even if the treatment results from an item or service described in subsection (a) of this section.

(g) This section shall not apply to grandfathered health plans.

27-19-65. Coverage for individuals participating in approved clinical trials. – (a) As used in this section:

(1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a life-threatening disease or condition and is described in any of the following:

(A) The study or investigation is approved or funded, which may include funding through in-kind contributions, by one or more of the following:

(i) The National Institutes of Health;

(ii) The Centers for Disease Control and Prevention;

(iii) The Agency for Health Care Research and Quality;

(iv) The Centers for Medicare & Medicaid Services;

(v) A cooperative group or center of any of the entities described in items (i) through (iv) or the Department of Defense or the Department of Veteran Affairs;

(vi) A qualified non-governmental research entity identified in the guidelines issued by

the National Institutes of Health for center support grants; or

(vii) A study or investigation conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of U.S. Department of Health and Human Services determines:

(I) Is comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(II) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

(2) "Participant" has the meaning stated in section 3(7) of ERISA.

(3) "Participating provider" means a health care provider that, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

(4) "Qualified individual" means a participant or beneficiary who meets the following conditions:

(A) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition; and

(B)(i) The referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate based on the individual meeting the conditions described in subdivision (A) of this subdivision (3); or

(ii) The participant or beneficiary provides medical and scientific information establishing the individual's participation in such trial would be appropriate based on the individual meeting the conditions described in subdivision (A) of this subdivision (3).

(5) "Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(b)(1) If a health insurance carrier offering group or individual health insurance coverage provides coverage to a qualified individual, the health carrier:

(A) Shall not deny the individual participation in an approved clinical trial.

(B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the approved clinical trial; and

(C)Shall not discriminate against the individual on the basis of the individual's participation in the approved clinical trial.

(2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all items and services consistent with the coverage typically covered for a qualified individual who is not enrolled in an approved clinical trial.

(B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not include:

(i) The investigational item, device or service itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(3) If one or more participating providers are participating in a clinical trial, nothing in subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection shall apply to a qualified individual participating in an approved clinical trial that is conducted outside this state.

(5) This section shall not be construed to require a health carrier offering group or individual health insurance coverage to provide benefits for routine patient care services provided outside of the coverage's health care provider network unless out-of-network benefits are otherwise provided under the coverage.

(6) Nothing in this section shall be construed to limit a health carrier's coverage with respect to clinical trials.

(c) The requirements of this section shall be in addition to the requirements of Rhode Island general laws sections 27-18-32 through 27-19-32.2.

(d) This section shall not apply to grandfathered health plans.

(e) This section shall be effective for plan years beginning on or after January 1, 2014.

27-19-66. Medical loss ratio rebates. – (a) A nonprofit hospital service corporation offering group or individual health insurance coverage, including a grandfathered health plan,

shall pay medical loss ratio rebates as provided for in Section 2718(b)(1)(A) of the Affordable Care Act, in the manner and as required by federal laws and regulations.

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

27-19-67. Emergency services. – (a) As used in this section:

(1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) Placing the health of the individual, or with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part.

(2) "Emergency services" means, with respect to an emergency medical condition:

(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

(3) "Stabilize", with respect to an emergency medical condition has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) If a nonprofit hospital service corporation provides any benefits to subscribers with respect to services in an emergency department of a hospital, the plan must cover emergency services consistent with the rules of this section.

(c) A nonprofit hospital service corporation shall provide coverage for emergency services in the following manner:

(1) Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

(2) Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services;

(3) If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements

or limitations that apply to emergency services received from in-network providers;

(4) If the emergency services are provided out of network, by complying with the cost-sharing requirements of subsection (d) of this section; and

(5) Without regard to any other term or condition of the coverage, other than:

(A) The exclusion of or coordination of benefits;

(B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or

(C) Applicable cost sharing.

(d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network. However, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or health insurance carrier is required to pay under subdivision (1) of this subsection. A group health plan or health insurance carrier complies with the requirements of this subsection if it provides benefits with respect to an emergency service in an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision (1)(which are adjusted for in-network cost-sharing requirements).

(A) The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. If there is more than one amount negotiated with in-network providers for the emergency service, the amount described under this subdivision (A) is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. In determining the median described in the preceding sentence, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount under this subdivision (A) is disregarded.

(B) The amount for the emergency service shall be calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is determined without reduction for out-of-network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services. Thus, for example, if a

plan generally pays seventy percent (70%) of the usual, customary, and reasonable amount for out-of-network services, the amount in this subdivision (B) for an emergency service is the total, that is, one hundred percent (100%), of the usual, customary, and reasonable amount for the service, not reduced by the thirty percent (30%) coinsurance that would generally apply to out-of-network services (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).

(C) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary.

(2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services provided out of network if the cost-sharing requirement generally applies to out-of-network benefits. A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-network emergency services.

(e) The provisions of this section apply for plan years beginning on or after September 23, 2010.

(f) This section shall not apply to grandfathered health plans.

27-19-68. Internal and external appeal of adverse benefit determinations. – (a) The commissioner shall adopt regulations to implement standards and procedures with respect to internal claims and appeals of adverse benefit determinations, and with respect to external appeals of adverse benefit determinations.

(b) The regulations adopted by the commissioner shall apply to those adverse benefit determinations within the jurisdiction of the commissioner.

SECTION 6. Sections 27-20-1 and 27-20-45 of the General laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" are hereby amended to read as follows:

27-20-1. Definitions. -- As used in this chapter:

(1) Adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan or to receive coverage under a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a

benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The term also includes a rescission of coverage determination.

(2) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

~~(1)~~(3) "Certified registered nurse practitioners" is an expanded role utilizing independent knowledge of physical assessment and management of health care and illnesses. The practice includes collaboration with other licensed health care professionals including, but not limited to, physicians, pharmacists, podiatrists, dentists, and nurses;

(4) “Commissioner” or “health insurance commissioner” means that individual appointed pursuant to section 42-14.5-1 of the General laws.

~~(2)~~(5) "Counselor in mental health" means a person who has been licensed pursuant to section 5-63.2-9.

(6) “Grandfathered health plan” means any group health plan or health insurance coverage subject to 42 USC section 18011.

(7) “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(8) “Group health plan” means an employee welfare benefit plan as defined in 29 USC section 1002(1) to the extent that the plan provides health benefits to employees or their dependents directly or through insurance, reimbursement, or otherwise.

(9) “Health benefits” or “covered benefits” means medical, surgical, hospital, prescription drug, and such other benefits, whether self-funded, or delivered through the purchase of insurance or otherwise.

(10) “Health care facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(11) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(12) "Health care provider" or "provider" means a health care professional or a health care facility.

(13) "Health care services" means services for the diagnosis, prevention, treatment, cure

or relief of a health condition, illness, injury or disease.

(14) “Health insurance carrier” means a person, firm, corporation or other entity subject to the jurisdiction of the commissioner under this chapter, and includes a nonprofit medical service corporation. Such term does not include a group health plan.

(15) "Health plan" or “health benefit plan” means health insurance coverage and a group health plan, including coverage provided through an association plan if it covers Rhode Island residents. Except to the extent specifically provided by the Affordable Care Act, the term ‘‘health plan’’ shall not include a group health plan to the extent state regulation of the health plan is pre-empted under section 514 of the Employee Retirement Income Security Act of 1974. The term also shall not include:

(A)(i) Coverage only for accident, or disability income insurance, or any combination thereof.

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

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

(iv) Workers’ compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, the health insurance portability and accountability act of 1996 (“HIPAA”), under which benefits for medical care are secondary or incidental to other insurance benefits.

(B) The following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Other excepted benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191 (“HIPAA”).

(C) The following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

(ii) Hospital indemnity or other fixed indemnity insurance.

(D) The following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplement health insurance as defined under section 1882(g)(1) of the Social Security Act.

(ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

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

~~(3)~~(16) "Licensed midwife" means any midwife licensed under section 23-13-9;

~~(4)~~(17) "Medical services" means those professional services rendered by persons duly licensed under the laws of this state to practice medicine, surgery, chiropractic, podiatry, and other professional services rendered by a licensed midwife, certified registered nurse practitioners, and psychiatric and mental health nurse clinical specialists, and appliances, drugs, medicines, supplies, and nursing care necessary in connection with the services, or the expense indemnity for the services, appliances, drugs, medicines, supplies, and care, as may be specified in any nonprofit medical service plan. Medical service shall not be construed to include hospital services;

~~(5)~~(18) "Nonprofit medical service corporation" means any corporation organized pursuant hereto for the purpose of establishing, maintaining, and operating a nonprofit medical service plan;

~~(6)~~(19) "Nonprofit medical service plan" means a plan by which specified medical service is provided to subscribers to the plan by a nonprofit medical service corporation;

(20) "Office of the health insurance commissioner" means the agency established under section 42-14.5-1 of the General laws.

~~(7)~~(21) "Psychiatric and mental health nurse clinical specialist" is an expanded role utilizing independent knowledge and management of mental health and illnesses. The practice includes collaboration with other licensed health care professionals, including, but not limited to, psychiatrists, psychologists, physicians, pharmacists, and nurses;

(22) “Rescission" means a cancellation or discontinuance of coverage that has retroactive effect for reasons unrelated to timely payment of required premiums or contribution to costs of coverage.

~~(8)~~(23) "Subscribers" means those persons or groups of persons who contract with a nonprofit medical service corporation for medical service pursuant to a nonprofit medical service plan; and

~~(9)~~(24) "Therapist in marriage and family practice" means a person who has been licensed pursuant to section 5-63.2-10.

27-20-45. ~~Termination of children's benefits~~ Eligibility for children's benefits. -- (a) Every individual health insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state and every group health insurance contract, plan, or policy delivered, issued for delivery or renewed in this state which provides ~~medical~~ health benefits coverage for ~~dependent children that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage~~ dependents, except for supplemental policies which only provide coverage for specified diseases and other supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried child under the age of nineteen (19) years, an unmarried child who is a student under the age of twenty five (25) years and who is financially dependent upon the parent and an unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months~~ for children until attainment of twenty-six (26) years of age. ~~Such contract, plan or policy shall also include a provision that policyholders shall receive no less than thirty (30) days notice from the nonprofit medical service corporation that a child covered as a dependent by the policyholder is about to lose his or her coverage as a result of reaching the maximum age for a dependent child and that the child will only continue to be covered upon documentation being provided of current full or part-time enrollment in a post-secondary educational institution, or that the child may purchase a conversion policy if he or she is not an eligible student.~~

~~(b) Nothing in this section prohibits a nonprofit medical service corporation from requiring a policyholder to annually provide proof of a child's current full or part-time enrollment in a post-secondary educational institution in order to maintain the child's coverage. Provided, nothing in this section requires coverage inconsistent with the membership criteria in effect under the policyholder's health benefits coverage.~~

(2) With respect to a child who has not attained twenty-six (26) years of age, a nonprofit medical service corporation shall not define “dependent” for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the plan participant, and, in the individual market, primary subscriber.

(3) A nonprofit medical service corporation shall not deny or restrict coverage for a child who has not attained twenty-six (26) years of age based on the presence or absence of the child’s financial dependency upon the participant, primary subscriber or any other person, residency with

the participant and in the individual market the primary subscriber, or with any other person, marital status, student status, employment or any combination of those factors. A nonprofit medical service corporation shall not deny or restrict coverage of a child based on eligibility for other coverage, except as provided in (d)(1) of this section.

(4) Nothing in this section shall be construed to require a health insurance carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

(5) The terms of coverage in a health benefit plan offered by a nonprofit medical service corporation r providing dependent coverage of children cannot vary based on age except for children who are twenty-six (26) years of age or older.

(b)(1) This subsection applies to any child:

(A) Whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage of a child ended before the attainment of twenty-six (26) years of age; and

(B) Who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010 by reason of the provisions of this section.

(2)(A) If group health insurance coverage or individual health insurance coverage, in which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in which the child's coverage ended or did not begin for the reasons described in subdivision (1) of this subsection, and if the health insurance carrier is subject to the requirements of this section the health insurance carrier shall give the child an opportunity to enroll that continues for at least sixty (60) days, including the written notice of the opportunity to enroll as described subdivision (3) of this subsection.

(B) The health insurance carrier shall provide the opportunity to enroll, including the written notice beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.

(3)(A) The written notice of opportunity to enroll shall include a statement that children whose coverage ended, or who were denied coverage, or were not eligible for coverage, because the availability of dependent coverage of children ended before the attainment of twenty-six (26) years of age are eligible to enroll in the coverage.

(B)(i) The notice may be provided to an employee on behalf of the employee's child and, in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

(ii) For group health insurance coverage:

(I)The notice may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent; and

(II) If a notice satisfying the requirements of this subdivision is provided to an employee whose child is entitled to an enrollment opportunity under subsection (c) of this section, the obligation to provide the notice of enrollment opportunity under subdivision (B) of this subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.

(C) The written notice shall be provided beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.

(4) For an individual who enrolls under this subsection, the coverage shall take effect not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

(c)(1) A child enrolling in group health insurance coverage pursuant to subsection (b) of this section shall be treated as if the child were a special enrollee, as provided under regulations interpreting the HIPAA portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

(2)(A) The child and, if the child would not be a participant once enrolled, the participant through whom the child is otherwise eligible for coverage under the plan, shall be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(B) For purposes of this subdivision (2), any difference in benefits or cost-sharing requirements constitutes a different benefit package.

(3) The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(d)(1) For plan years beginning before January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered health plan and makes available dependent coverage of children may exclude an adult child who has not attained twenty-six (26) years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

(2) For plan years, beginning on or after January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered health plan shall comply with the requirements of subsections (a) through (e).

(3) The provisions of this section apply to policy years in the individual market on and after September 23, 2010.

~~(b)~~(e) This section does not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other limited benefit policies.

SECTION 7. Chapter 27-20 of the General laws entitled "Nonprofit Medical Service Corporations" is hereby amended by adding thereto the following sections:

27-20-6.1. Uniform explanation of benefits and coverage. – (a) A nonprofit medical service corporation shall provide a uniform summary of benefits and coverage explanation and standardized definitions to policyholders and others required by, and at the times required by the federal regulations adopted under section 2715 of the Affordable Care Act. The summary required by this section shall be filed with the commissioner for approval under Rhode Island general laws section 27-20-6.2. The requirements of this section shall be in addition to the requirements of Rhode Island general laws section 27-20-6.2. The commissioner may waive one or more of the requirements of the regulations adopted under section 2715 of the Affordable Care Act for good cause shown. The summary must contain at least the following information:

(1) Uniform definitions of standard insurance and medical terms.

(2) A description of coverage and cost sharing for each category of essential benefits and other benefits.

(3) Exceptions, reductions and limitations in coverage.

(4) Renewability and continuation of coverage provisions.

(5) A “coverage facts label” that illustrates coverage under common benefits scenarios.

(6) A statement of whether the policy, contract or plan provides the minimum coverage required of a qualified health plan.

(7) A statement that the outline is a summary and that the actual policy language should be consulted; and

(8) A contact number for the consumer to call with additional questions and the web address of where the actual language of the policy, contract or plan can be found.

(b) The provisions of this section shall apply to grandfathered health plans.

27-20-6.2. Filing of policy forms. – A nonprofit medical service corporation shall file all policy forms and rates used by it in the state with the commissioner, including the forms of any rider, endorsement, application blank, and other matter generally used or incorporated by reference in its policies or contracts of insurance. No such rate shall be used unless first approved

by the commissioner. No such form shall be used if disapproved by the commissioner under this section, or if the commissioner's approval has been withdrawn after notice and an opportunity to be heard, or until the expiration of sixty (60) days following the filing of the form. A nonprofit medical service corporation shall comply with its filed and approved rates and forms. If the commissioner finds from an examination of any form that it is contrary to the public interest, or the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the corporation in writing. Each form shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance with applicable laws and that the benefits are reasonable in relation to the premium to be charged.

27-20-62. Prohibition on rescission of coverage. – (a)(1) Coverage under a health benefit plan subject to the jurisdiction of the commissioner under this chapter with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, shall not be subject to rescission after the individual is covered under the plan, unless:

(A)The individual or a person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud; or

(B)The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

(2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an individual does not include an insurance producer or employee or authorized representative of the health carrier.

(b) At least thirty (30) days advance written notice shall be provided to each plan enrollee or, for individual health insurance coverage, primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection (a) regardless of, in the case of group health insurance coverage, whether the rescission applies to the entire group or only to an individual within the group.

(d) This section applies to grandfathered health plans.

27-20-63. Annual and lifetime limits. – (a) Annual limits.

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

(A) For a plan or policy year beginning after September 22, 2010, but before September 23, 2011 – seven hundred fifty thousand dollars ($750,000);

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

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

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

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

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

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

(b) Lifetime limits.

(1) A health insurance carrier and health benefit plan offering group or individual health insurance coverage shall not establish a lifetime limit on the dollar value of essential health benefits, as designated pursuant to a state determination and in accordance with federal laws and regulations, for any individual.

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

(c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this subsection, this subsection applies to any individual:

(A) Whose coverage or benefits under a health plan ended by reason of reaching a lifetime limit on the dollar value of all benefits for the individual; and

(B) Who, due to the provisions of this section, becomes eligible, or is required to become eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the

health benefit plan:

(i) For group health insurance coverage, on the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, on the first day of the first policy year beginning on or after September 23, 2010.

(2) For individual health insurance coverage, an individual is not entitled to reinstatement under the health benefit plan under this subsection if the individual reached his or her lifetime limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection applies to a family member who reached his or her lifetime limit in a family plan and other family members remain covered under the plan.

(3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to become eligible for benefits under the health benefit plan, the health carrier shall provide the individual written notice that:

(i) The lifetime limit on the dollar value of all benefits no longer applies; and

(ii) The individual, if still covered under the plan, is again eligible to receive benefits under the plan.

(B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for, but not enrolled in any benefit package under the plan, the health benefit plan shall provide an opportunity for the individual to enroll in the plan for a period of at least thirty (30) days.

(C) The notices and enrollment opportunity under this subdivision shall be provided beginning not later than:

(i) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

(iii) The notices required under this subsection shall be provided:

(I) For group health insurance coverage, to an employee on behalf of the employee's dependent; or

(II) For individual health insurance coverage, to the primary subscriber on behalf of the primary subscriber's dependent.

(D) For group health insurance coverage, the notices may be included with other enrollment materials that a health plan distributes to employees, provided the statement is prominent. For group health insurance coverage, if a notice satisfying the requirements of this subsection is provided to an individual, a health insurance carrier's requirement to provide the

notice with respect to that individual is satisfied.

(E) For any individual who enrolls in a health plan in accordance with subdivision (2) of this subsection, coverage under the plan shall take effect not later than:

(i) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

(d)(1) An individual enrolling in a health plan for group health insurance coverage in accordance with subsection (c) above shall be treated as if the individual were a special enrollee, as provided under regulations interpreting the Health Insurance Portability and Accountability Act ("HIPAA") portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

(2) An individual enrolling in accordance with subsection (c) above:

(A) shall be offered all of the benefit packages available to similarly situated individuals who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value of all benefits; and

(B) shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

(3) For purposes of subsection B(1), any difference in benefits or cost-sharing constitutes a different benefit package.

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

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

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

27-20-64. Coverage for preventive items and services. – (a) Every health insurance carrier providing coverage under an individual or group health plan shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(1) Except as otherwise provided in subsection (b) of this section, and except as may otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States preventive services task force as of September 23, 201 and as may subsequently be

amended.

(2) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

(3) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(4) With respect to women, to the extent not described in subdivision (1) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive coverage guidelines supported by the Health Resources and Services Administration.

(b)(1) A health insurance carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection (a) of this section after the recommendation or guideline is no longer described in subsection (a) of this section. The provisions of this subdivision shall not affect the obligation of the health insurance carrier to provide notice to a covered person before any material modification of coverage becomes effective, in accordance with other requirements of state and federal law, including section 2715(d)(4) of the Public Health Services Act.

(2) A health insurance carrier shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

(c)(1) A health insurance carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is billed separately or is tracked as individual encounter data separately from the office visit.

(2) A health insurance carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is not billed

separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service described in subsection (a) of this section.

(3) A health insurance carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

(d)(1) Nothing in this section requires a health insurance carrier that has a network of providers to providing coverage for items and services described in subsection (a) of this section that are delivered by an out-of-network provider.

(2) Nothing in subsection (a) of this section precludes a health insurance carrier that has a network of providers from imposing cost-sharing requirements for items or services described in subsection (a) of this section that are delivered by an out-of-network provider.

(e) Nothing prevents a health insurance carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in subsection (a) of this section to the extent not specified in the recommendation or guideline.

(f) Nothing in this section prohibits a health insurance carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health insurance carrier may impose cost-sharing requirements for a treatment not described in subsection (a) of this section even if the treatment results from an item or service described in subsection (a) of this section.

(g) This section shall not apply to grandfathered health plans.

27-20-65. Coverage for individuals participating in approved clinical trials. – (a) As used in this section,

(1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a life-threatening disease or condition and is described in any of the following:

(A) The study or investigation is approved or funded, which may include funding through in-kind contributions, by one or more of the following:

(i) The National Institutes of Health;

(ii) The Centers for Disease Control and Prevention;

(iii) The Agency for Health Care Research and Quality;

(iv) The Centers for Medicare & Medicaid Services;

(v) A cooperative group or center of any of the entities described in items (i) through (iv) or the Department of Defense or the Department of Veteran Affairs;

(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(vii) A study or investigation conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of U.S. Department of Health and Human Services determines:

(I) Is comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(II) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

(2) “Participant” has the meaning stated in section 3(7) of ERISA.

(3) “Participating provider” means a health care provider that, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

(4) “Qualified individual” means a participant or beneficiary who meets the following conditions:

(A) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition; and

(B)(i) The referring health care professional is a participating provider and has concluded that the individual’s participation in such trial would be appropriate based on the individual meeting the conditions described in subdivision (A) of this subdivision (3); or

(ii) The participant or beneficiary provides medical and scientific information

establishing the individual's participation in such trial would be appropriate based on the individual meeting the conditions described in subdivision (A) of this subdivision (3).

(5) "Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(b)(1) If a health insurance carrier offering group or individual health insurance coverage provides coverage to a qualified individual, the health carrier:

(A) Shall not deny the individual participation in an approved clinical trial.

(B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical approved trial; and

(C) Shall not discriminate against the individual on the basis of the individual's participation in the clinical trial.

(2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all items and services consistent with the coverage typically covered for a qualified individual who is not enrolled in an approved clinical trial.

(B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not include:

(i) The investigational item, device or service itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(3) If one or more participating providers is participating in a clinical trial, nothing in subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection shall apply to a qualified individual participating in an approved clinical trial that is conducted outside this state.

(5) This section shall not be construed to require a nonprofit medical service corporation offering group or individual health insurance coverage to provide benefits for routine patient care services provided outside of the coverage's health care provider network unless out-of-network benefits are otherwise provided under the coverage.

(6) Nothing in this section shall be construed to limit a health insurance carrier's

coverage with respect to clinical trials.

(c) The requirements of this section shall be in addition to the requirements of Rhode Island general laws sections 27-18-36 through 27-18-36.3.

(d) This section shall not apply to grandfathered health plans.

(e) This section shall be effective for plan years beginning on or after January 1, 2014.

27-20-66. Medical loss ratio rebates. – (a) A nonprofit medical service corporation offering group or individual health insurance coverage, including a grandfathered health plan, shall pay medical loss ratio rebates as provided for in Section 2718(b)(1)(A) of the Affordable Care Act, in the manner and as required by federal laws and regulations.

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

27-20-67. Emergency services -- (a) As used in this section:

(1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) Placing the health of the individual, or with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part

(2) "Emergency services" means, with respect to an emergency medical condition:

(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

(3) "Stabilize", with respect to an emergency medical condition has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) If a nonprofit medical service corporation offering health insurance coverage provides any benefits with respect to services in an emergency department of a hospital, it must cover emergency services consistent with the rules of this section.

(c) A nonprofit medical service corporation shall provide coverage for emergency services in the following manner:

(1) Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

(2) Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services;

(3) If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers;

(4) If the emergency services are provided out of network, by complying with the cost-sharing requirements of subsection (d) of this section; and

(5) Without regard to any other term or condition of the coverage, other than:

(A) The exclusion of or coordination of benefits;

(B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or

(C) Applicable cost-sharing.

(d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network. However, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or health insurance carrier is required to pay under subdivision (1) of this subsection. A group health plan or health insurance carrier complies with the requirements of this subsection if it provides benefits with respect to an emergency service in an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision (1)(which are adjusted for in-network cost-sharing requirements).

(A) The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. If there is more than one amount negotiated with in-network providers for the emergency service, the amount described under this subdivision (A) is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. In determining the median described in the preceding sentence, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with

in-network providers (such as under a capitation or other similar payment arrangement), the amount under this subdivision (A) is disregarded.

(B) The amount for the emergency service shall be calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is determined without reduction for out-of-network cost-sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services.

(C) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary.

(2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services provided out of network if the cost-sharing requirement generally applies to out-of-network benefits. A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-network emergency services.

(e) The provisions of this section apply for plan years beginning on or after September 23, 2010.

(f) This section shall not apply to grandfathered health plans.

27-20-68. Internal and external appeal of adverse benefit determinations. -- (a) The commissioner shall adopt regulations to implement standards and procedures with respect to internal claims and appeals of adverse benefit determinations, and with respect to external appeals of adverse benefit determinations.

(b) The regulations adopted by the commissioner shall apply to those adverse benefit determinations within the jurisdiction of the commissioner.

SECTION 8. Sections 27-41-2 and 27-41-61 of the General laws in Chapter 27-41 entitled "Health Maintenance Organizations" are hereby amended to read as follows:

27-41-2. Definitions. – As used in this chapter:

(a) Adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan or to

receive coverage under a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The term also includes a rescission of coverage determination.

(b) "Affordable Care Act" means the Patient Protection and Affordable Care act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

(c) “Commissioner” or “health insurance commissioner” means that individual appointed pursuant to section 42-14.5-1 of the general laws.

~~(a)~~(d) "Covered health services" means the services that a health maintenance organization contracts with enrollees and enrolled groups to provide or make available to an enrolled participant.

~~(b)~~ (e) "Director" means the director of the department of business regulation or his or her duly appointed agents.

~~(c)~~(f) "Employee" means any person who has entered into the employment of or works under a contract of service or apprenticeship with any employer. It shall not include a person who has been employed for less than thirty (30) days by his or her employer, nor shall it include a person who works less than an average of thirty (30) hours per week. For the purposes of this chapter, the term "employee" means a person employed by an "employer" as defined in subsection (d) of this section. Except as otherwise provided in this chapter the terms "employee" and "employer" are to be defined according to the rules and regulations of the department of labor and training.

~~(d)~~(g) "Employer" means any person, partnership, association, trust, estate, or corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy, receiver, or trustee of a receiver, or the legal representative of a deceased person, including the state of Rhode Island and each city and town in the state, which has in its employ one or more individuals during any calendar year. For the purposes of this section, the term "employer" refers only to an employer with persons employed within the state of Rhode Island.

~~(e)~~(h) "Enrollee" means an individual who has been enrolled in a health maintenance organization.

~~(f)~~(i) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which the enrollee is entitled.

(j) “Grandfathered health plan” means any group health plan or health insurance coverage

subject to 42 USC section 18011.

(k) “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(l) “Group health plan” means an employee welfare benefit plan as defined in 29 USC section 1002(1), to the extent that the plan provides health benefits to employees or their dependents directly or through insurance, reimbursement, or otherwise.

(m) “Health benefits” or “covered benefits” means medical, surgical, hospital, prescription drug, and such other benefits, whether self-funded, or delivered through the purchase of insurance or otherwise.

(n) “Health care facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(o) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(p) "Health care provider" or "provider" means a health care professional or a health care facility.

~~(g)~~(q) "Health care services" means any services included in the furnishing to any individual of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of that care or hospitalization, and the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

(r) “Health insurance carrier” means a person, firm, corporation or other entity subject to the jurisdiction of the commissioner under this chapter, and includes a health maintenance organization. Such term does not include a group health plan.

~~(h)~~(s) "Health maintenance organization" means a single public or private organization which:

(1) Provides or makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency, and preventive services, and out of area coverage, and the services of licensed midwives;

(2) Is compensated, except for copayments, for the provision of the basic health care services listed in subdivision (1) of this subsection to enrolled participants on a predetermined periodic rate basis; and

(3) Provides physicians' services primarily:

(A) Directly through physicians who are either employees or partners of the organization; or

(B) Through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis;

(ii) "Health maintenance organization" does not include prepaid plans offered by entities regulated under chapter 1, 2, 19, or 20 of this title that do not meet the criteria above and do not purport to be health maintenance organizations;

(4) Provides the services of licensed midwives primarily:

(i) Directly through licensed midwives who are either employees or partners of the organization; or

(ii) Through arrangements with individual licensed midwives or one or more groups of licensed midwives organized on a group practice or individual practice basis.

~~(i)~~(t) "Licensed midwife" means any midwife licensed pursuant to section 23-13-9.

~~(j)~~(u) "Material modification" means only systemic changes to the information filed under section 27-41-3.

~~(k)~~(v) "Net worth", for the purposes of this chapter, means the excess of total admitted assets over total liabilities.

(w) "Office of the health insurance commissioner" means the agency established under section 42-14.5-1 of the general laws.

~~(l)~~(x) "Physician" includes podiatrist as defined in chapter 29 of title 5.

~~(m)~~(y) "Private organization" means a legal corporation with a policy making and governing body.

~~(n)~~(z) "Provider" means any physician, hospital, licensed midwife, or other person who is licensed or authorized in this state to furnish health care services.

~~(o)~~(aa) "Public organization" means an instrumentality of government.

(bb) “Rescission" means a cancellation or discontinuance of coverage that has retroactive effect for reasons unrelated to timely payment of required premiums or contribution to costs of coverage.

~~(p)~~(cc) "Risk based capital ("RBC") instructions" means the risk based capital report including risk based capital instructions adopted by the National Association of Insurance Commissioners ("NAIC"), as these risk based capital instructions are amended by the NAIC in accordance with the procedures adopted by the NAIC.

~~(q)~~(dd) "Total adjusted capital" means the sum of:

(1) A health maintenance organization's statutory capital and surplus (i.e. net worth) as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under section 27-41-9; and

(2) Any other items, if any, that the RBC instructions provide.

~~(r)~~(ee) "Uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization, but that are not guaranteed, insured, or assumed by a person or organization other than the health maintenance organization. Expenditures to a provider that agrees not to bill enrollees under any circumstances are excluded from this definition.

27-41-61. ~~Termination of children's benefits.~~ Eligibility for children's benefits - (a)(1) Every individual health insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state which provides ~~medical~~ health benefits coverage for ~~dependent children that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage,~~ dependents, except for supplemental policies which only provide coverage for specified diseases and other supplemental policies, shall ~~provide~~ make coverage available ~~of an unmarried child under the age of nineteen (19) years, an unmarried child who is a student under the age of twenty-five (25) years and who is financially dependent upon the parent and an unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months.~~ for children until attainment of twenty-six (26) years of age. ~~Such contract, plan or policy shall also include a provision that policyholders shall receive no less than thirty (30) days notice from the health maintenance organization that a child is about to lose his or her coverage as a result of reaching the maximum age for a dependent child and that the child will only continue to be covered upon documentation being provided of current full or part-time enrollment in a post-secondary educational institution, or that the child may purchase a conversion policy if he or she is not an eligible student.~~

~~(b) Nothing in this section prohibits a nonprofit health maintenance organization from requiring a policyholder to annually provide proof of a child's current full or part-time enrollment in a post-secondary educational institution in order to maintain the child's coverage. Provided, nothing in this section requires coverage inconsistent with the membership criteria in effect under the policyholder's health benefits coverage.~~

(2) With respect to a child who has not attained twenty-six (26) years of age, a health maintenance organization shall not define "dependent" for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the plan

participant, and, in the individual market, primary subscriber.

(3) A health maintenance organization shall not deny or restrict coverage for a child who has not attained twenty-six (26) years of age based on the presence or absence of the child's financial dependency upon the participant, primary subscriber or any other person, residency with the participant and in the individual market the primary subscriber, or with any other person, marital status, student status, employment or any combination of those factors. A health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage, except as provided in (d)(1) of this section.

(4) Nothing in this section shall be construed to require a health maintenance organization to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

(5) The terms of coverage in a health benefit plan offered by a health maintenance organization providing dependent coverage of children cannot vary based on age except for children who are twenty-six (26) years of age or older.

(b)(1) This subsection applies to any child:

(A) Whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage of a child ended before the attainment of twenty-six (26) years of age; and

(B) Who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010 by reason of the provisions of this section.

(2)(A) If group health insurance coverage or individual health insurance coverage, in which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in which the child's coverage ended or did not begin for the reasons described in subdivision (1) of this subsection, and if the health insurance carrier is subject to the requirements of this section the health insurance carrier shall give the child an opportunity to enroll that continues for at least 60 days, including the written notice of the opportunity to enroll as described subdivision (3) of this subsection.

(B) The health insurance carrier shall provide the opportunity to enroll, including the written notice beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.

(3)(A) The written notice of opportunity to enroll shall include a statement that children whose coverage ended, or who were denied coverage, or were not eligible for coverage, because

the availability of dependent coverage of children ended before the attainment of twenty-six (26) years of age are eligible to enroll in the coverage.

(B)(i) The notice may be provided to an employee on behalf of the employee's child and, in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

(ii) For group health insurance coverage:

(I) The notice may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent; and

(II) If a notice satisfying the requirements of this subdivision is provided to an employee whose child is entitled to an enrollment opportunity under subsection (c) of this section, the obligation to provide the notice of enrollment opportunity under subdivision (B) of this subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.

(C) The written notice shall be provided beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.

(4) For an individual who enrolls under this subsection, the coverage shall take effect not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

(c)(1) A child enrolling in group health insurance coverage pursuant to subsection (b) of this section shall be treated as if the child were a special enrollee, as provided under regulations interpreting the HIPAA portability provisions issued pursuant to section 2714 of the Affordable Care.

(2)(A) The child and, if the child would not be a participant once enrolled, the participant through whom the child is otherwise eligible for coverage under the plan, shall be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(B) For purposes of this subdivision (2), any difference in benefits or cost-sharing requirements constitutes a different benefit package.

(3) The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(d)(1) For plan years beginning before January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered health plan and makes available dependent coverage of children may exclude an adult child who has not attained twenty-six (26) years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code,

other than the group health plan of a parent.

(2) For plan years, beginning on or after January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered health plan shall comply with the requirements of subsections (a) through (e).

(3) The provisions of this section apply to policy years in the individual market on and after September 23, 2010.

~~(b)~~(e) This section does not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other limited benefit policies.

SECTION 9. Chapter 27-41 of the General laws entitled "Health Maintenance Organizations" is hereby amended by adding thereto the following sections:

27-41-29.1. Uniform explanation of benefits and coverage. -- (a) A health maintenance organization shall provide a uniform summary of benefits and coverage explanation and standardized definitions to policyholders and others required by, and at the times required by, the federal regulations adopted under section 2715 of the Affordable Care Act. A summary required by this section shall be filed with the commissioner for approval under Rhode Island general laws section 27-41-29.2. The requirements of this section shall be in addition to any other requirements imposed as conditions of approval under Rhode Island general laws sections 27-41-29.2. The commissioner may waive one or more of the requirements of the regulations adopted under section 2715 of the Affordable Care Act for good cause shown. The summary must contain at least the following information:

(1) Uniform definitions of insurance and medical terms.

(2) A description of coverage and cost-sharing for each category of essential benefits and other benefits.

(3) Exceptions, reductions and limitations in coverage.

(4) Renewability and continuation of coverage provisions.

(5) A “coverage facts label” that illustrates coverage under common benefits scenarios.

(6) A statement of whether the policy, contract or plan provides the minimum coverage required of a qualified health plan.

(7) A statement that the outline is a summary and that the actual policy language should be consulted; and

(8) A contact number for the consumer to call with additional questions and the web address of where the actual language of the policy, contract or plan can be found.

(b) The provisions of this section shall apply to grandfathered health plans.

27-41-29.2. Filing of policy forms. -- A health maintenance organization shall file all policy forms and rates used by it in the state with the commissioner, including the forms of any rider, endorsement, application blank, and other matter generally used or incorporated by reference in its policies or contracts of insurance. No such rate shall be used unless first approved by the commissioner. No such form shall be used if disapproved by the commissioner under this section, or if the commissioner's approval has been withdrawn after notice and an opportunity to be heard, or until the expiration of sixty (60) days following the filing of the form. A health maintenance organization shall comply with its filed and approved rates and forms. If the commissioner finds from an examination of any form that it is contrary to the public interest or the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the corporation in writing. Each form shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance with applicable laws and that the benefits are reasonable in relation to the premium to be charged.

27-41-75. Prohibition on rescission of coverage. -- (a)(1) Coverage under a health plan subject to the jurisdiction of the commissioner under this chapter with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, shall not be rescinded after the individual is covered under the plan, unless:

(A) The individual or a person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud; or

(B) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

(2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an individual does not include an insurance producer or employee or authorized representative of the health maintenance organization.

(b) At least thirty (30) days advance written notice shall be provided to each plan enrollee or, for individual health insurance coverage, primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection (a) regardless of, in the case of group health insurance coverage, whether the rescission applies to the entire group or only to an individual within the group.

(c) For purposes of this section, “to rescind” means to cancel or to discontinue coverage with retroactive effect for reasons unrelated to timely payment of required premiums or contribution to costs of coverage.

(d) This section applies to grandfathered health plans.

27-41-76. Prohibition on annual and lifetime limits. -- (a) Annual limits.

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

(A) For a plan or policy year beginning after September 22, 2010, but before September 23, 2011 – seven hundred fifty thousand dollars ($750,000);

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

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

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

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

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

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

(b) Lifetime limits.

(1) A health insurance carrier and health benefit plan offering group or individual health insurance coverage shall not establish a lifetime limit on the dollar value of essential health benefits, as designated pursuant to a state determination and in accordance with federal laws and regulations, for any individual.

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

in accordance with federal laws and regulations.

(c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this subsection, this subsection applies to any individual:

(A) Whose coverage or benefits under a health plan ended by reason of reaching a lifetime limit on the dollar value of all benefits for the individual; and

(B) Who, due to the provisions of this section, becomes eligible, or is required to become eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the health benefit plan:

(i) For group health insurance coverage, on the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, on the first day of the first policy year beginning on or after September 23, 2010.

(2) For individual health insurance coverage, an individual is not entitled to reinstatement under the health benefit plan under this subsection if the individual reached his or her lifetime limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection applies to a family member who reached his or her lifetime limit in a family plan and other family members remain covered under the plan.

(3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to become eligible for benefits under the health benefit plan, the health maintenance organization shall provide the individual written notice that:

(i) The lifetime limit on the dollar value of all benefits no longer applies; and

(ii) The individual, if still covered under the plan, is again eligible to receive benefits under the plan.

(B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for, but not enrolled in any benefit package under the plan, the health maintenance organization shall provide an opportunity for the individual to enroll in the plan for a period of at least thirty (30) days.

(C) The notices and enrollment opportunity under this subdivision shall be provided beginning not later than:

(i) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

(iii) The notices required under this subsection shall be provided:

(I) For group health insurance coverage, to an employee on behalf of the employee's dependent; or

(II) For individual health insurance coverage, to the primary subscriber on behalf of the primary subscriber's dependent.

(D) For group health insurance coverage, the notices may be included with other enrollment materials that a health maintenance organization distributes to subscribers, provided the statement is prominent. For group health insurance coverage, if a notice satisfying the requirements of this subsection is provided to an individual, a health maintenance organization's requirement to provide the notice with respect to that individual is satisfied.

(E) For any individual who enrolls in a health maintenance organization in accordance with subdivision (2) of this subsection, coverage under the plan shall take effect not later than:

(i) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or

(ii) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

(d)(1) An individual enrolling in a health maintenance organization for group health insurance coverage in accordance with subsection (c) above shall be treated as if the individual were a special enrollee in the plan, as provided under regulations interpreting the HIPAA portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

(2) An individual enrolling in accordance with subsection (c) of this subsection:

(A) shall be offered all of the benefit packages available to similarly situated individuals who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value of all benefits; and

(B) shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

(3) For purposes of subsection B(1), any difference in benefits or cost-sharing constitutes a different benefit package.

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

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

27-41-77. Coverage for Preventive Items and Services. -- (a) Every health maintenance organization providing coverage under an individual or group health plan shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(1) Except as otherwise provided in subsection (b) of this section, and except as may otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010 and as may subsequently be amended.

(2) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

(3) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(4) With respect to women, to the extent not described in subdivision (1) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive coverage guidelines supported by the Health Resources and Services Administration.

(b)(1) A health maintenance organization is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection (a) of this section after the recommendation or guideline is no longer described in subsection (a) of this section. The provisions of this subdivision shall not affect the obligation of the health maintenance organization to provide notice to a covered person before any material modification of coverage becomes effective, in accordance with including section 2715(d)(4) of the Public Health Services Act.

(2) A health maintenance organization shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization

Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

(c)(1) A health maintenance organization insurance carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is billed separately or is tracked as individual encounter data separately from the office visit.

(2) A health maintenance organization shall not impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service described in subsection (a) of this section.

(3) A health maintenance organization may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

(d)(1) Nothing in this section requires a health maintenance organization that has a network of providers to providing coverage for items and services described in subsection (a) of this section that are delivered by an out-of-network provider.

(2) Nothing in subsection (a) of this section precludes a health maintenance organization insurance carrier that has a network of providers from imposing cost-sharing requirements for items or services described in subsection (a) of this section that are delivered by an out-of-network provider.

(e) Nothing prevents a health maintenance organization from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in subsection (a) of this section to the extent not specified in the recommendation or guideline.

(f) Nothing in this section prohibits a health maintenance organization from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health maintenance organization may impose cost-sharing requirements for a treatment not

described in subsection (a) of this section even if the treatment results from an item or service described in subsection (a) of this section.

(g) This section shall not apply to grandfathered health plans.

27-41-78. Coverage for individual participating in approved clinical trials. -- (a) As used in this section.

(1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a life-threatening disease or condition and is described in any of the following:

(A) The study or investigation is approved or funded, which may include funding through in-kind contributions, by one or more of the following:

(i) The National Institutes of Health;

(ii) The Centers for Disease Control and Prevention;

(iii) The Agency for Health Care Research and Quality;

(iv) The Centers for Medicare & Medicaid Services;

(v) A cooperative group or center of any of the entities described in items (i) through (iv) or the Department of Defense or the Department of Veteran Affairs;

(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(vii) A study or investigation conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of U.S. Department of Health and Human Services determines:

(I) Is comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(II) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

(2) "Participant" has the meaning stated in section 3(7) of ERISA.

(3) "Participating provider" means a health care provider that, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or

deductibles, directly or indirectly from the health carrier.

(4) "Qualified individual" means a participant or beneficiary who meets the following conditions:

(A) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition; and

(B)(i) The referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate based on the individual meeting the conditions described in subdivision (A) of this subdivision (3); or

(ii) The participant or beneficiary provides medical and scientific information establishing the individual's participation in such trial would be appropriate based on the individual meeting the conditions described in subdivision (A) of this subdivision (3).

(5) "Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(b)(1) If a health maintenance organization offering group or individual health insurance coverage provides coverage to a qualified individual, it:

(A) Shall not deny the individual participation in an approved clinical trial.

(B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the approved clinical trial; and

(C) Shall not discriminate against the individual on the basis of the individual's participation in the approved clinical trial.

(2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all items and services consistent with the coverage typically covered for a qualified individual who is not enrolled in an approved clinical trial.

(B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not include:

(i) The investigational item, device or service itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(3) If one or more participating providers is participating in a clinical trial, nothing in subdivision (1) of this subsection shall be construed as preventing a health maintenance

organization from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection shall apply to a qualified individual participating in an approved clinical trial that is conducted outside this state.

(5) This section shall not be construed to require a health maintenance organization offering group or individual health insurance coverage to provide benefits for routine patient care services provided outside of the coverage's health care provider network unless out-of-network benefits are other provided under the coverage.

(6) Nothing in this section shall be construed to limit a health maintenance organization's coverage with respect to clinical trials.

(c) The requirements of this section shall be in addition to the requirements of Rhode Island general laws sections 27-41-41 through 27-41-41.3.

27-41-79. Medical loss ratio rebates. -- (a) A health maintenance organization offering group or individual health insurance coverage, including a grandfathered health plan, shall pay medical loss ratio rebates as provided for in section 2718(b)(1)(A) of the Affordable Care Act, in the manner and as required by federal laws and regulations.

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

27-41-80. Emergency services. -- (a) As used in this section:

(1)"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) Placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy: (ii) Constituting a serious impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part.

(2) "Emergency services" means, with respect to an emergency medical condition:

(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395 dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the

capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395 dd) to stabilize the patient.

(3) “Stabilize”, with respect to an emergency medical condition has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C.1395 dd(e)(3)).

(b) If a health maintenance organization offering group health insurance coverage provides any benefits with respect to services in an emergency department of a hospital, it must cover emergency services consistent with the rules of this section.

(c) A health maintenance organization shall provide coverage for emergency services in the following manner:

(1) Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

(2) Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services;

(3) If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers;

(4) If the emergency services are provided out of network, by complying with the cost-sharing requirements of subsection (d) of this section; and

(5) Without regard to any other term or condition of the coverage, other than:

(A) The exclusion of or coordination of benefits;

(B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or

(C) Applicable cost sharing.

(d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network; provided, however, that a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or health maintenance organization is required to pay under subdivision (1) of this subsection. A health maintenance organization complies with the requirements of this subsection if it provides benefits with respect to an emergency service in an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision (1)(which are adjusted for in-network cost-sharing requirements).

(A) The amount negotiated with in-network providers for the emergency service

furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. If there is more than one amount negotiated with in-network providers for the emergency service, the amount described under this subdivision (A) is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. In determining the median described in the preceding sentence, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount under this subdivision (A) is disregarded.

(B) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is determined without reduction for out-of-network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services.

(C) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary.

(2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services provided out of network if the cost-sharing requirement generally applies to out-of-network benefits. A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-network emergency services.

(e) The provisions of this section apply for plan years beginning on or after September 23, 2010.

(f) This section shall not apply to grandfathered health plans.

27-41-81. Internal and external appeal of adverse benefit determinations. -- (a) The commissioner shall adopt regulations to implement standards and procedures with respect to internal claims and appeals of adverse benefit determinations, and with respect to external appeals of adverse benefit determinations.

(b) The regulations adopted by the commissioner shall apply to those adverse benefit determinations within the jurisdiction of the commissioner.

SECTION 10. Section 42-14-5 of the General laws in Chapter 42-14 entitled "Department of Business Regulation" is hereby amended to read as follows:

42-14-5. Administrator of banking and insurance. -- (a) The director of business regulation shall, in addition to his or her regular duties, act as administrator of banking and insurance and shall administer the functions of the department relating to the regulation and control of banking and insurance, foreign surety companies, sale of securities, building and loan associations, and fraternal benefit and beneficiary societies.

(b) Wherever the words "banking administrator" or "insurance administrator" occur in this chapter or any general law, public law, act, or resolution of the general assembly or department regulation, they shall be construed to mean banking commissioner and insurance commissioner except as delineated in subsection (d) below.

(c) "Health insurance" shall mean "health insurance coverage," as defined in 27-18.5-2 and 27-18.6-2, "health benefit plan," as defined in 27-50-3 and a "medical supplement policy," as defined in 27-18.2-1or coverage similar to a Medicare supplement policy that is issued to an employer to cover retirees, and dental coverage, including, but not limited to, coverage provided by a nonprofit dental service plan as defined in subsection 27-20.1-1(3).

(d) Whenever the words "commissioner," "insurance commissioner", "Health insurance commissioner" or "director" appear in Title 27or Title 42, those words shall be construed to mean the health insurance commissioner established pursuant to 42-14.5-1with respect to all matters relating to health insurance. The health insurance commissioner shall have sole and exclusive jurisdiction over enforcement of those statutes with respect to all matters relating to health insurance.

(e) In consultation with the commissioner of health, the health insurance commissioner shall have concurrent jurisdiction to monitor, examine, and enforce the requirements of title 23 and regulations adopted thereunder relating to health insurance.

SECTION 11. Applicability. This act shall apply to health insurance policies, subscriber contracts, and any other health benefit contract on and after July 1, 2012, except as otherwise provided by the provisions of this act.

SECTION 12. This act shall take effect on passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- HEALTH INSURANCE - CONSUMER PROTECTION

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This act would establish health insurance rules and standards in addition to, but not inconsistent with, the health insurance standards established in the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010. These rules and standards would include, but are not limited to, prohibitions on rescission of coverage, discrimination in coverage, and prohibitions on annual and lifetime limits of coverage unless such limits meet set minimum amounts, as well as adding definitions to the chapters covering health insurance.

This act would take effect upon passage.

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