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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2012

AN ACT

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:

1 SECTION 1. Purpose and intent.

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

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

9 **27-18-1.1. Definitions. –** As used in this chapter:

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

1 (2) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act
2 of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and
3 federal regulations adopted thereunder.
4 (3) "Commissioner" or "health insurance commissioner" means that individual appointed
5 pursuant to section 42-14.5-1 of the general laws.
6 (4) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the
7 federal Affordable Care Act,
8 (5) "Grandfathered health plan" means any group health plan or health insurance
9 coverage subject to 42 USC section 18011.
10 (6) "Group health insurance coverage" means, in connection with a group health plan,
11 health insurance coverage offered in connection with such plan.
12 (7) "Group health plan" means an employee welfare benefit plan, as defined in 29 USC
13 section 1002(1), to the extent that the plan provides health benefits to employees or their
14 dependents directly or through insurance, reimbursement, or otherwise.
15 (8) "Health benefits" or "covered benefits" means coverage or benefits for the diagnosis,
16 cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting
17 any structure or function of the body including coverage or benefits for transportation primarily
18 for and essential thereto, and including medical services as defined in R.I. Gen. Laws § 27-19-17;
19 (9) "Health care facility" means an institution providing health care services or a health
20 care setting, including, but not limited to, hospitals and other licensed inpatient centers,
21 ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers,
22 diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health
23 settings.
24 (10) "Health care professional" means a physician or other health care practitioner
25 licensed, accredited or certified to perform specified health care services consistent with state
26 law.
27 (11) "Health care provider" or "provider" means a health care professional or a health
28 care facility.
29 (12) "Health care services" means services for the diagnosis, prevention, treatment, cure
30 or relief of a health condition, illness, injury or disease.
31 (13) "Health insurance carrier" means a person, firm, corporation or other entity subject
32 to the jurisdiction of the commissioner under this chapter. Such term does not include a group
33 health plan.
34 (14) "Health plan" or "health benefit plan" means health insurance coverage and a group

1 health plan, including coverage provided through an association plan if it covers Rhode Island
2 residents. Except to the extent specifically provided by the federal Affordable Care Act, the term
3 "health plan" shall not include a group health plan to the extent state regulation of the health plan
4 is pre-empted under section 514 of the federal Employee Retirement Income Security Act of
5 1974. The term also shall not include:
6 (A)(i) Coverage only for accident, or disability income insurance, or any combination
7 thereof.
8 (ii) Coverage issued as a supplement to liability insurance.
9 (iii) Liability insurance, including general liability insurance and automobile liability
10 insurance.
11 (iv) Workers' compensation or similar insurance.
12 (v) Automobile medical payment insurance.
13 (vi) Credit-only insurance.
14 (vii) Coverage for on-site medical clinics.
15 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant to
16 Pub. L. No. 104-191, the federal health insurance portability and accountability act of 1996
17 ("HIPAA"), under which benefits for medical care are secondary or incidental to other insurance
18 benefits.
19 (B) The following benefits if they are provided under a separate policy, certificate or
20 contract of insurance or are otherwise not an integral part of the plan:
21 (i) Limited scope dental or vision benefits.
22 (ii) Benefits for long-term care, nursing home care, home health care, community-based
23 care, or any combination thereof.
24 (iii) Other excepted benefits specified in federal regulations issued pursuant to federal
25 Pub. L. No. 104-191 ("HIPAA").
26 (C) The following benefits if the benefits are provided under a separate policy, certificate
27 or contract of insurance, there is no coordination between the provision of the benefits and any
28 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the
29 benefits are paid with respect to an event without regard to whether benefits are provided with
30 respect to such an event under any group health plan maintained by the same plan sponsor:
31 (i) Coverage only for a specified disease or illness.
32 (ii) Hospital indemnity or other fixed indemnity insurance.
33 (D) The following if offered as a separate policy, certificate or contract of insurance:
34 (i) Medicare supplement health insurance as defined under section 1882(g)(1) of the

1 federal Social Security Act.

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

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

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

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

10 **27-18-2.1. Uniform explanation of benefits and coverage. –** (a) A health insurance
11 carrier shall provide a summary of benefits and coverage explanation and definitions to
12 policyholders and others required by, and at the times and in the format required, by the federal
13 regulations adopted under section 2715 of the Public Health Service Act, as amended by the
14 federal Affordable Care Act. The forms required by this section shall be made available to the
15 commissioner on request. Nothing in this section shall be construed to limit the authority of the
16 commissioner under existing state law.

17 (b) The provisions of this section shall apply to grandfathered health plans. This section
18 shall not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity;
19 (2) disability income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited
20 benefit health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident
21 or both; and (9) other limited benefit policies.

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

29 **27-18-71. Prohibition on preexisting condition exclusions. –** (a) A health insurance
30 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a
31 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

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

34 (2) For plan or policy years beginning on or after January 1, 2014, shall not limit or

exclude coverage for any individual by imposing a preexisting condition exclusion on that individual.

(b) As used in this section:

(1) "Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition (whether physical or mental) was present before the effective date of coverage, or if the coverage is denied, the date of denial, under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was recommended or received before the effective date of coverage.

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

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

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

27-18-72. 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

1 be affected by the proposed rescission of coverage before coverage under the plan may be
2 rescinded in accordance with subsection (a) regardless of, in the case of group health insurance
3 coverage, whether the rescission applies to the entire group or only to an individual within the
4 group.
5 (c) For purposes of this section, "to rescind" means to cancel or to discontinue coverage
6 with retroactive effect for reasons unrelated to timely payment of required premiums or
7 contribution to costs of coverage.
8 (d) This section applies to grandfathered health plans.
9 **27-18-73. Prohibition on annual and lifetime limits. –** (a) Annual limits.
10 (1) For plan or policy years beginning prior to January 1, 2014, for any individual, a
11 health insurance carrier and a health benefit plan subject to the jurisdiction of the commissioner
12 under this chapter may establish an annual limit on the dollar amount of benefits that are essential
13 health benefits provided the restricted annual limit is not less than the following:
14 (A) For a plan or policy year beginning after September 22, 2011, but before September
15 23, 2012 – one million two hundred fifty thousand dollars ($1,250,000); and
16 (B) For a plan or policy year beginning after September 22, 2012, but before January 1,
17 2014 – two million dollars ($2,000,000).
18 (2) For plan or policy years beginning on or after January 1, 2014, a health insurance
19 carrier and a health benefit plan shall not establish any annual limit on the dollar amount of
20 essential health benefits for any individual, except:
21 (A) A health flexible spending arrangement, as defined in Section 106(c)(2)(i) of the
22 Federal Internal Revenue Code, a medical savings account, as defined in section 220 of the
23 federal Internal Revenue Code, and a health savings account, as defined in Section 223 of the
24 federal Internal Revenue Code are not subject to the requirements of subdivisions (1) and (2) of
25 this subsection.
26 (B) The provisions of this subsection shall not prevent a health insurance carrier and a
27 health benefit plan from placing annual dollar limits for any individual on specific covered
28 benefits that are not essential health benefits to the extent that such limits are otherwise permitted
29 under applicable federal law or the laws and regulations of this state.
30 (3) In determining whether an individual has received benefits that meet or exceed the
31 allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier and a
32 health benefit plan shall take into account only essential health benefits.
33 (b) Lifetime limits.
34 (1) A health insurance carrier and health benefit plan offering group or individual health

1 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
2 benefits for any individual.
3 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
4 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
5 benefits that are not essential health benefits, in accordance with federal laws and regulations.
6 (c)(1) The provisions of this section relating to lifetime limits apply to any health
7 insurance carrier providing coverage under an individual or group health plan, including
8 grandfathered health plans.
9 (2) The provisions of this section relating to annual limits apply to any health insurance
10 carrier providing coverage under a group health plan, including grandfathered health plans, but
11 the prohibition and limits on annual limits do not apply to grandfathered health plans providing
12 individual health insurance coverage.
13 (d) This section shall not apply to a plan or to policy years prior to January 1, 2014 for
14 which the Secretary of the U.S. Department of Health and Human Services issued a waiver
15 pursuant to 45 C.F.R. § 147.126(d)(3). This section also shall not apply to insurance coverage
16 providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident
17 only; (4) long term care; (5) Medicare supplement; (6) limited benefit health; (7) specified disease
18 indemnity; (8) sickness or bodily injury or death by accident or both; and (9) other limited benefit
19 policies.
20 (e) If the commissioner of the office of the health insurance commissioner determines
21 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
22 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
23 an act of Congress, on the date of the commissioner's determination this section shall have its
24 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
25 section. Nothing in this subsection shall be construed to limit the authority of the Commissioner
26 to regulate health insurance under existing state law.
27 **27-18-74. Coverage for individuals participating in approved clinical trials. –** (a) As
28 used in this section,
29 (1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial
30 That is conducted in relation to the prevention, detection or treatment of cancer or a life-
31 threatening disease or condition and is described in any of the following:
32 (A) The study or investigation is approved or funded, which may include funding through
33 in-kind contributions, by one or more of the following:
34 (i) The federal National Institutes of Health;

1 (ii) The federal Centers for Disease Control and Prevention;

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

3 (iv) The federal Centers for Medicare & Medicaid Services;

4 (v) A cooperative group or center of any of the entities described in items (i) through (iv)

5 or the U.S. Department of Defense or the U.S. Department of Veteran Affairs;

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

7 the federal National Institutes of Health for center support grants; or

8 (vii) A study or investigation conducted by the U.S. Department of Veteran Affairs, the

9 U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has

10 been reviewed and approved through a system of peer review that the Secretary of U.S.

11 Department of Health and Human Services determines:

12 (I) Is comparable to the system of peer review of studies and investigations used by the

13 federal National Institutes of Health; and

14 (II) Assures unbiased review of the highest scientific standards by qualified individuals

15 who have no interest in the outcome of the review.

16 (B) The study or investigation is conducted under an investigational new drug application

17 reviewed by the U.S. Food and Drug Administration; or

18 (C) The study or investigation is a drug trial that is exempt from having such an

19 investigational new drug application.

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

21 (3) "Participating provider" means a health care provider that, under a contract with the

22 health carrier or with its contractor or subcontractor, has agreed to provide health care services to

23 covered persons with an expectation of receiving payment, other than coinsurance, copayments or

24 deductibles, directly or indirectly from the health carrier.

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

26 conditions:

27 (A) The individual is eligible to participate in an approved clinical trial according to the

28 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;

29 and

30 (B)(i) The referring health care professional is a participating provider and has concluded

31 that the individual's participation in such trial would be appropriate based on the individual

32 meeting the conditions described in subdivision (A) of this subdivision (3); or

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

34 establishing the individual's participation in such trial would be appropriate based on the

1 individual meeting the conditions described in subdivision (A) of this subdivision (3).

2 (5) "Life-threatening condition" means any disease or condition from which the

3 likelihood of death is probable unless the course of the disease or condition is interrupted.

4 (b)(1) If a health insurance carrier offering group or individual health insurance coverage

5 provides coverage to a qualified individual, the health insurance carrier:

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

7 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose

8 additional conditions on the coverage of routine patient costs for items and services furnished in

9 connection with participation in the approved clinical trial; and

10 (C) Shall not discriminate against the individual on the basis of the individual's

11 participation in the approved clinical trial.

12 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all

13 items and services consistent with the coverage typically covered for a qualified individual who is

14 not enrolled in an approved clinical trial.

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

16 include:

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

18 (ii) Items and services that are provided solely to satisfy data collection and analysis

19 needs and that are not used in the direct clinical management of the patient; or

20 (iii) A service that is clearly inconsistent with widely accepted and established standards

21 of care for a particular diagnosis.

22 (3) If one or more participating providers are participating in a clinical trial, nothing in

23 subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring

24 that a qualified individual participate in the trial through such a participating provider if the

25 provider will accept the individual as a participant in the trial.

26 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection

27 shall apply to a qualified individual participating in an approved clinical trial that is conducted

28 outside this state.

29 (5) This section shall not be construed to require a health insurance carrier offering group

30 or individual health insurance coverage to provide benefits for routine patient care services

31 provided outside of the coverage's health care provider network unless out-of-network benefits

32 are otherwise provided under the coverage.

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

34 coverage with respect to clinical trials.

1 (c) The requirements of this section shall be in addition to the requirements of Rhode
2 Island general laws sections 27-18-36 through 27-18-36.3.
3 (d) This section shall not apply to grandfathered health plans. This section shall not apply
4 to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability
5 income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit
6 health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both;
7 and (9) other limited benefit policies.
8 (e) This section shall be effective for plan years beginning on or after January 1, 2014.
9 **27-18-75. Medical loss ratio reporting and rebates. –** (a) A health insurance carrier
10 offering group or individual health insurance coverage of a health benefit plan, including a
11 grandfathered health plan, shall comply with the provisions of Section 2718 of the Public Health
12 Services Act as amended by the federal Affordable Care Act, in accordance with regulations
13 adopted thereunder.
14 (b) Health insurance carriers required to report medical loss ratio and rebate calculations
15 and other medical loss ratio and rebate information to the U.S. Department of Health and Human
16 Services shall concurrently file such information with the commissioner.
17 **27-18-76. Emergency services. –** (a) As used in this section:
18 (1) "Emergency medical condition" means a medical condition manifesting itself by
19 acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
20 possesses an average knowledge of health and medicine, could reasonably expect the absence of
21 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
22 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
23 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
24 part.
25 (2) "Emergency services" means, with respect to an emergency medical condition:
26 (A) A medical screening examination (as required under section 1867 of the Social
27 Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a
28 hospital, including ancillary services routinely available to the emergency department to evaluate
29 such emergency medical condition, and
30 (B) Such further medical examination and treatment, to the extent they are within the
31 capabilities of the staff and facilities available at the hospital, as are required under section 1867
32 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.
33 (3) "Stabilize", with respect to an emergency medical condition has the meaning given in
34 section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

1 (b) If a health insurance carrier offering health insurance coverage provides any benefits
2 with respect to services in an emergency department of a hospital, the carrier must cover
3 emergency services in compliance with this section.
4 (c) A health insurance carrier shall provide coverage for emergency services in the
5 following manner:
6 (1) Without the need for any prior authorization determination, even if the emergency
7 services are provided on an out-of-network basis;
8 (2) Without regard to whether the health care provider furnishing the emergency services
9 is a participating network provider with respect to the services;
10 (3) If the emergency services are provided out of network, without imposing any
11 administrative requirement or limitation on coverage that is more restrictive than the requirements
12 or limitations that apply to emergency services received from in-network providers;
13 (4) If the emergency services are provided out of network, by complying with the cost-
14 sharing requirements of subsection (d) of this section; and
15 (5) Without regard to any other term or condition of the coverage, other than:
16 (A) The exclusion of or coordination of benefits;
17 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
18 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or
19 (C) Applicable cost-sharing.
20 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
21 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
22 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
23 the services were provided in-network; provided, however, that a participant or beneficiary may
24 be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-
25 network provider charges over the amount the health insurance carrier is required to pay under
26 subdivision (1) of this subsection. A health insurance carrier complies with the requirements of
27 this subsection if it provides benefits with respect to an emergency service in an amount equal to
28 the greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision
29 (1)(which are adjusted for in-network cost-sharing requirements).
30 (A) The amount negotiated with in-network providers for the emergency service
31 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
32 participant or beneficiary. If there is more than one amount negotiated with in-network providers
33 for the emergency service, the amount described under this subdivision (A) is the median of these
34 amounts, excluding any in-network copayment or coinsurance imposed with respect to the

1 participant or beneficiary. In determining the median described in the preceding sentence, the
2 amount negotiated with each in-network provider is treated as a separate amount (even if the
3 same amount is paid to more than one provider). If there is no per-service amount negotiated with
4 in-network providers (such as under a capitation or other similar payment arrangement), the
5 amount under this subdivision (A) is disregarded.
6 (B) The amount for the emergency service shall be calculated using the same method the
7 plan generally uses to determine payments for out-of-network services (such as the usual,
8 customary, and reasonable amount), excluding any in-network copayment or coinsurance
9 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
10 determined without reduction for out-of-network cost-sharing that generally applies under the
11 plan or health insurance coverage with respect to out-of-network services.
12 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
13 Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network
14 copayment or coinsurance imposed with respect to the participant or beneficiary.
15 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
16 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
17 services provided out of network if the cost-sharing requirement generally applies to out-of-
18 network benefits. A deductible may be imposed with respect to out-of-network emergency
19 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
20 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
21 apply to out-of-network emergency services.
22 (e) The provisions of this section apply for plan years beginning on or after September
23 23, 2010.
24 (f) This section shall not apply to grandfathered health plans. This section shall not apply
25 to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability
26 income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit
27 health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both;
28 and (9) other limited benefit policies.
29 **27-18-77. Internal and external appeal of adverse benefit determinations. –** (a) The
30 commissioner shall adopt regulations to implement standards and procedures with respect to
31 internal claims and appeals of adverse benefit determinations, and with respect to external appeals
32 of adverse benefit determinations.
33 (b) The regulations adopted by the commissioner shall apply only to those adverse
34 benefit determinations which are not subject to the jurisdiction of the department of health

pursuant to R.I. Gen. Laws § 23-17.12 et seq. (Utilization Review Act).

(c) This section shall not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both; and (9) other limited benefit policies. This section also shall not apply to grandfathered health plans.

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 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 and forms. If the commissioner finds from a 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.

(b) Each rate filing shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws and that the benefits offered or proposed to be offered are reasonable in relation to the premium to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

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.

1 (b)(1)(A) Any health plan, nonprofit medical service plan or nonprofit hospital service
2 plan, including a health insurance carrier or a health maintenance organization which requires or
3 provides for the designation by a covered person of a participating primary health care
4 professional shall permit each covered person to:
5 (i) Designate any participating primary care health care professional who is available to
6 accept the covered person; and
7 (ii) For a child, designate any participating physician who specializes in pediatrics as the
8 child's primary care health care professional and is available to accept the child.
9 (2) The provisions of subdivision (1) of this subsection shall not be construed to waive
10 any exclusions of coverage under the terms and conditions of the health benefit plan with respect
11 to coverage of pediatric care.
12 (c)(1) If a health plan, nonprofit medical service plan or nonprofit hospital service plan,
13 including a health insurance carrier or a health maintenance organization, provides coverage for
14 obstetrical or gynecological care and requires the designation by a covered person of a
15 participating primary care health care professional, then it:
16 (A) Shall not require any person's, including a primary care health care professional's,
17 prior authorization or referral in the case of a female covered person who seeks coverage for
18 obstetrical or gynecological care provided by a participating health care professional who
19 specializes in obstetrics or gynecology; and
20 (B) Shall treat the provision of obstetrical and gynecological care, and the ordering of
21 related obstetrical and gynecological items and services, pursuant to subdivision (A) of this
22 subdivision (c)(1), by a participating health care professional who specializes in obstetrics or
23 gynecology as the authorization of the primary care health care professional.
24 (2)(A) A health plan, nonprofit medical service plan or nonprofit hospital service plan,
25 including a health insurance carrier or a health maintenance organization may require the health
26 care professional to agree to otherwise adhere to its policies and procedures, including procedures
27 relating to referrals, obtaining prior authorization, and providing services in accordance with a
28 treatment plan, if any, approved by the plan, carrier or health maintenance organization.
29 (B)For purposes of subdivision (A) of this subdivision (c)(1), a health care professional,
30 who specializes in obstetrics or gynecology, means any individual, including an individual other
31 than a physician, who is authorized under state law to provide obstetrical or gynecological care.
32 (3) The provisions of subdivision (A) of this subdivision (c)(1) shall not be construed to:
33 (A) Waive any exclusions of coverage under the terms and conditions of the health
34 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 federal regulation 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. This section shall not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both; and (9) other limited benefit policies.

27-18-59. ~~Termination of children's benefits~~ Eligibility for children's benefits. -- (a)(1) Every ~~individual health insurance contract, plan, or policy~~ health benefit plan 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, 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. ~~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, or 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 (b)(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) 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 federal 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.

~~(b)~~(c)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) sickness or bodily injury or death by accident or both; or (9) other limited benefit policies.

SECTION 4. Chapter 27-18.5 of the General Laws entitled “Individual Health Insurance Coverage” is hereby amended by adding thereto the following section:

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

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

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

(b) As used in this section:

(1) “Preexisting condition exclusion” means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition (whether physical or mental) was present before the effective date of coverage, or if the coverage is denied, the date of denial, under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was recommended or received before the effective date of coverage.

(2) “Preexisting condition exclusion” means any limitation or exclusion of benefits, including a denial of coverage, applicable to an individual as a result of information relating to an individual’s health status before the individual’s effective date of coverage, or if the coverage is

1 denied, the date of denial, under the health benefit plan, such as a condition (whether physical or
2 mental) identified as a result of a pre-enrollment questionnaire or physical examination given to
3 the individual, or review of medical records relating to the pre-enrollment period.
4 (c) This section shall not apply to grandfathered health plans providing individual health
5 insurance coverage.
6 (d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
7 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
8 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
9 bodily injury or death by accident or both; and (9) Other limited benefit policies.
10 SECTION 5. Sections 27-19-1 and 27-19-50 of the General laws in Chapter 27-19
11 entitled "Nonprofit Hospital Service Corporations" are hereby amended to read as follows:
12 **27-19-1. Definitions. --** As used in this chapter:
13 (1) "Contracting hospital" means an eligible hospital which has contracted with a
14 nonprofit hospital service corporation to render hospital care to subscribers to the nonprofit
15 hospital service plan operated by the corporation;
16 (2) "Adverse benefit determination" means any of the following: a denial, reduction, or
17 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,
18 including any such denial, reduction, termination, or failure to provide or make payment that is
19 based on a determination of an individual's eligibility to participate in a plan or to receive
20 coverage under a plan, and including, with respect to group health plans, a denial, reduction, or
21 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit
22 resulting from the application of any utilization review, as well as a failure to cover an item or
23 service for which benefits are otherwise provided because it is determined to be experimental or
24 investigational or not medically necessary or appropriate. The term also includes a rescission of
25 coverage determination.
26 (3) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act
27 of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and
28 federal regulations adopted thereunder;
29 (4) “Commissioner” or “health insurance commissioner” means that individual appointed
30 pursuant to section 42-14.5-1 of the General laws;
31 (5) "Eligible hospital" is one which is maintained either by the state or by any of its
32 political subdivisions or by a corporation organized for hospital purposes under the laws of this
33 state or of any other state or of the United States, which is designated as an eligible hospital by a
34 majority of the directors of the nonprofit hospital service corporation;

(6) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the federal Affordable Care Act.

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

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

(9) “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;

(10) “Health benefits” or “covered benefits” means coverage or benefits for the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body including coverage or benefits for transportation primarily for and essential thereto, and including medical services as defined in R.I. Gen. Laws § 27-19-17;

(11) “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;

(12) "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;

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

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

(15) “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. The use of this term shall not be construed to subject a nonprofit hospital service corporation to the insurance laws of this state other than as set forth in R.I. Gen. Laws § 27-19-2;

(16) "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 federal 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 federal 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 federal Pub. L. No. 104-191, the federal 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 federal 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 federal 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.

(17) "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;

(18) "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;

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

(20) "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

(21) "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 health benefit plan 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, 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. 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.~~

~~(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 or 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 (b)(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) 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 federal 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 this section.

(c) 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 6. 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 summary of benefits and coverage explanation and definitions to policyholders and others required by, and at the times and in the format required, by the federal regulations adopted under section 2715 of the Public Health Service Act, as amended by the federal Affordable Care Act. The forms required by this section shall be made available to the commissioner on request. Nothing in this section shall be construed to limit the authority of the commissioner under existing state law.

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

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

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 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. Such a company shall comply with its filed and approved 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.

(b) Each rate filing shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws and that the benefits offered or proposed to be offered are reasonable in relation to the premium to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

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, 2011, but before September 23, 2012 – one million two hundred fifty thousand dollars ($1,250,000); and

(B) For a plan or policy year beginning after September 22, 2012, but before January 1,

2014 – two million dollars ($2,000,000).

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

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

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

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

(b) Lifetime limits.

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

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

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

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

(d) This section shall not apply to a plan or to policy years prior to January 1, 2014 for which the Secretary of the U.S. Department of Health and Human Services issued a waiver pursuant to 45 C.F.R. § 147.126(d)(3)This section also shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident

1 only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified
2 disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other
3 limited benefit policies.
4 (e) If the commissioner of the office of the health insurance commissioner determines
5 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
6 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
7 an act of Congress, on the date of the commissioner's determination this section shall have its
8 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
9 section. Nothing in this subsection shall be construed to limit the authority of the Commissioner
10 to regulate health insurance under existing state law.
11 **27-19-64. Coverage for individuals participating in approved clinical trials. –** (a) As
12 used in this section:
13 (1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial
14 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
15 threatening disease or condition and is described in any of the following:
16 (A) The study or investigation is approved or funded, which may include funding through
17 in-kind contributions, by one or more of the following:
18 (i) The federal National Institutes of Health;
19 (ii) The federal Centers for Disease Control and Prevention;
20 (iii) The federal Agency for Health Care Research and Quality;
21 (iv) The federal Centers for Medicare & Medicaid Services;
22 (v) A cooperative group or center of any of the entities described in items (i) through (iv)
23 or the U.S. Department of Defense or the U.S. Department of Veterans' Affairs;
24 (vi) A qualified non-governmental research entity identified in the guidelines issued by
25 the federal National Institutes of Health for center support grants; or
26 (vii) A study or investigation conducted by the U.S. Department of Veterans' Affairs, the
27 U.S. Department of Defense, or the U.S. Department of Energy, if the study or
28 investigation has been reviewed and approved through a system of peer review that the Secretary
29 of U.S. Department of Health and Human Services determines:
30 (I) Is comparable to the system of peer review of studies and investigations used by the
31 Federal National Institutes of Health; and
32 (II) Assures unbiased review of the highest scientific standards by qualified individuals
33 who have no interest in the outcome of the review.
34 (B) The study or investigation is conducted under an investigational new drug application

1 reviewed by the U.S. Food and Drug Administration; or

2 (C) The study or investigation is a drug trial that is exempt from having such an

3 investigational new drug application.

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

5 (3) "Participating provider" means a health care provider that, under a contract with the

6 health carrier or with its contractor or subcontractor, has agreed to provide health care services to

7 covered persons with an expectation of receiving payment, other than coinsurance, copayments or

8 deductibles, directly or indirectly from the health carrier.

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

10 conditions:

11 (A) The individual is eligible to participate in an approved clinical trial according to the

12 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;

13 and

14 (B)(i) The referring health care professional is a participating provider and has concluded

15 that the individual's participation in such trial would be appropriate based on the individual

16 meeting the conditions described in subdivision (A) of this subdivision (3); or

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

18 establishing the individual's participation in such trial would be appropriate based on the

19 individual meeting the conditions described in subdivision (A) of this subdivision (3).

20 (5) "Life-threatening condition" means any disease or condition from which the

21 likelihood of death is probable unless the course of the disease or condition is interrupted.

22 (b)(1) If a health insurance carrier offering group or individual health insurance coverage

23 provides coverage to a qualified individual, the health carrier:

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

25 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose

26 additional conditions on the coverage of routine patient costs for items and services furnished in

27 connection with participation in the approved clinical trial; and

28 (C) Shall not discriminate against the individual on the basis of the individual's

29 participation in the approved clinical trial.

30 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all

31 items and services consistent with the coverage typically covered for a qualified individual who is

32 not enrolled in an approved clinical trial.

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

34 include:

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

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

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

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

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

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

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

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

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

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

27 **27-19-65. Medical loss ratio reporting and rebates. –** (a) A nonprofit hospital service
28 corporation offering group or individual health insurance coverage of a health benefit plan,
29 including a grandfathered health plan, shall comply with the provisions of Section 2718 of the
30 Public Health Services Act as amended by the federal Affordable Care Act, in accordance with
31 regulations adopted thereunder.

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

1 **27-19-66. Emergency services. –** (a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

34 (A) The exclusion of or coordination of benefits;

1 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
2 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or
3 (C) Applicable cost sharing.
4 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
5 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
6 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
7 the services were provided in-network. However, a participant or beneficiary may be required to
8 pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network
9 provider charges over the amount the plan or health insurance carrier is required to pay under
10 subdivision (1) of this subsection. A group health plan or health insurance carrier complies with
11 the requirements of this subsection if it provides benefits with respect to an emergency service in
12 an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
13 this subdivision (1)(which are adjusted for in-network cost-sharing requirements).
14 (A) The amount negotiated with in-network providers for the emergency service
15 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
16 participant or beneficiary. If there is more than one amount negotiated with in-network providers
17 for the emergency service, the amount described under this subdivision (A) is the median of these
18 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
19 participant or beneficiary. In determining the median described in the preceding sentence, the
20 amount negotiated with each in-network provider is treated as a separate amount (even if the
21 same amount is paid to more than one provider). If there is no per-service amount negotiated with
22 in-network providers (such as under a capitation or other similar payment arrangement), the
23 amount under this subdivision (A) is disregarded.
24 (B) The amount for the emergency service shall be calculated using the same method the
25 plan generally uses to determine payments for out-of-network services (such as the usual,
26 customary, and reasonable amount), excluding any in-network copayment or coinsurance
27 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
28 determined without reduction for out-of-network cost sharing that generally applies under the
29 plan or health insurance coverage with respect to out-of-network services. Thus, for example, if a
30 plan generally pays seventy percent (70%) of the usual, customary, and reasonable amount for
31 out-of-network services, the amount in this subdivision (B) for an emergency service is the total,
32 that is, one hundred percent (100%), of the usual, customary, and reasonable amount for the
33 service, not reduced by the thirty percent (30%) coinsurance that would generally apply to out-of-
34 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 insurance coverage providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other limited benefit policies.

27-19-67. 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 only to those adverse benefit determinations which are not subject to the jurisdiction of the department of health pursuant to R.I. Gen. Laws § 23-17.12 et seq. (Utilization Review Act).

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

27-19-68. Prohibition on preexisting condition exclusions. -- (a) A health insurance policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

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

1 (2) For plan or policy years beginning on or after January 1, 2014, shall not limit or
2 exclude coverage for any individual by imposing a preexisting condition exclusion on that
3 individual.
4 (b) As used in this section:
5 (1) "Preexisting condition exclusion" means a limitation or exclusion of benefits,
6 including a denial of coverage, based on the fact that the condition (whether physical or mental)
7 was present before the effective date of coverage, or if the coverage is denied, the date of denial,
8 under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was
9 recommended or received before the effective date of coverage.
10 (2) "Preexisting condition exclusion" means any limitation or exclusion of benefits,
11 including a denial of coverage, applicable to an individual as a result of information relating to an
12 individual's health status before the individual's effective date of coverage, or if the coverage is
13 denied, the date of denial, under the health benefit plan, such as a condition (whether physical or
14 mental) identified as a result of a pre-enrollment questionnaire or physical examination given to
15 the individual, or review of medical records relating to the pre-enrollment period.
16 (c) This section shall not apply to grandfathered health plans providing individual health
17 insurance coverage.
18 (d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
19 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
20 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
21 bodily injury or death by accident or both; and (9) Other limited benefit policies.
22 SECTION 7. Sections 27-20-1 and 27-20-45 of the General laws in Chapter 27-20
23 entitled "Nonprofit Medical Service Corporations" are hereby amended to read as follows:
24 **27-20-1. Definitions. --** As used in this chapter:
25 (1) Adverse benefit determination" means any of the following: a denial, reduction, or
26 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,
27 including any such denial, reduction, termination, or failure to provide or make payment that is
28 based on a determination of a an individual's eligibility to participate in a plan or to receive
29 coverage under a plan, and including, with respect to group health plans, a denial, reduction, or
30 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit
31 resulting from the application of any utilization review, as well as a failure to cover an item or
32 service for which benefits are otherwise provided because it is determined to be experimental or
33 investigational or not medically necessary or appropriate. The term also includes a rescission of
34 coverage determination.

1 (2) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act
2 of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and
3 federal regulations adopted thereunder;
4 (1)(3) "Certified registered nurse practitioners" is an expanded role utilizing independent
5 knowledge of physical assessment and management of health care and illnesses. The practice
6 includes collaboration with other licensed health care professionals including, but not limited to,
7 physicians, pharmacists, podiatrists, dentists, and nurses;
8 (4) "Commissioner" or "health insurance commissioner" means that individual appointed
9 pursuant to section 42-14.5-1 of the General laws.
10 (2)(5) "Counselor in mental health" means a person who has been licensed pursuant to
11 section 5-63.2-9.
12 (6) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the
13 federal Affordable Care Act.
14 (7) "Grandfathered health plan" means any group health plan or health insurance
15 coverage subject to 42 USC section 18011.
16 ((8) "Group health insurance coverage" means, in connection with a group health plan,
17 health insurance coverage offered in connection with such plan.
18 (9) "Group health plan" means an employee welfare benefit plan as defined in 29 USC
19 section 1002(1) to the extent that the plan provides health benefits to employees or their
20 dependents directly or through insurance, reimbursement, or otherwise.
21 (10) "Health benefits" or "covered benefits" means coverage or benefits for the
22 diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose
23 of affecting any structure or function of the body including coverage or benefits for transportation
24 primarily for and essential thereto, and including medical services as defined in R.I. Gen. Laws §
25 27-19-17;
26 (11) "Health care facility" means an institution providing health care services or a health
27 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory
28 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,
29 laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
30 (12) "Health care professional" means a physician or other health care practitioner
31 licensed, accredited or certified to perform specified health care services consistent with state
32 law.
33 (13) "Health care provider" or "provider" means a health care professional or a health
34 care facility.

1 (14) "Health care services" means services for the diagnosis, prevention, treatment, cure
2 or relief of a health condition, illness, injury or disease.
3 (15) “Health insurance carrier” means a person, firm, corporation or other entity subject
4 to the jurisdiction of the commissioner under this chapter, and includes a nonprofit medical
5 service corporation. Such term does not include a group health plan.
6 (16) "Health plan" or “health benefit plan” means health insurance coverage and a group
7 health plan, including coverage provided through an association plan if it covers Rhode Island
8 residents. Except to the extent specifically provided by the federal Affordable Care Act, the term
9 ‘‘health plan’’ shall not include a group health plan to the extent state regulation of the health
10 plan is pre- empted under section 514 of the federal Employee Retirement Income Security Act of
11 1974. The term also shall not include:
12 (A)(i) Coverage only for accident, or disability income insurance, or any combination
13 thereof.
14 (ii) Coverage issued as a supplement to liability insurance.
15 (iii) Liability insurance, including general liability insurance and automobile liability
16 insurance.
17 (iv) Workers’ compensation or similar insurance.
18 (v) Automobile medical payment insurance.
19 (vi) Credit-only insurance.
20 (vii) Coverage for on-site medical clinics.(viii) Other similar insurance coverage,
21 specified in federal regulations issued pursuant to Federal Pub. L. No. 104-191, the federal health
22 insurance portability and accountability act of 1996 (“HIPAA”), under which benefits for medical
23 care are secondary or incidental to other insurance benefits.
24 (B) The following benefits if they are provided under a separate policy, certificate or
25 contract of insurance or are otherwise not an integral part of the plan:
26 (i) Limited scope dental or vision benefits.
27 (ii) Benefits for long-term care, nursing home care, home health care, community-based
28 care, or any combination thereof.
29 (iii) Other excepted benefits specified in federal regulations issued pursuant to federal
30 Pub. L. No. 104-191 (“HIPAA”).
31 (C) The following benefits if the benefits are provided under a separate policy, certificate
32 or contract of insurance, there is no coordination between the provision of the benefits and any
33 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the
34 benefits are paid with respect to an event without regard to whether benefits are provided with

1 respect to such an event under any group health plan maintained by the same plan sponsor:

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

3 (ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

10 ~~(3)~~(17)"Licensed midwife" means any midwife licensed under section 23-13-9;

11 ~~(4)~~(18) "Medical services" means those professional services rendered by persons duly
12 licensed under the laws of this state to practice medicine, surgery, chiropractic, podiatry, and
13 other professional services rendered by a licensed midwife, certified registered nurse
14 practitioners, and psychiatric and mental health nurse clinical specialists, and appliances, drugs,
15 medicines, supplies, and nursing care necessary in connection with the services, or the expense
16 indemnity for the services, appliances, drugs, medicines, supplies, and care, as may be specified
17 in any nonprofit medical service plan. Medical service shall not be construed to include hospital
18 services;

19 ~~(5)~~(19) "Nonprofit medical service corporation" means any corporation organized
20 pursuant hereto for the purpose of establishing, maintaining, and operating a nonprofit medical
21 service plan;

22 ~~(6)~~(20) "Nonprofit medical service plan" means a plan by which specified medical
23 service is provided to subscribers to the plan by a nonprofit medical service corporation;

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

26 ~~(7)~~(22) "Psychiatric and mental health nurse clinical specialist" is an expanded role
27 utilizing independent knowledge and management of mental health and illnesses. The practice
28 includes collaboration with other licensed health care professionals, including, but not limited to,
29 psychiatrists, psychologists, physicians, pharmacists, and nurses;

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

33 ~~(8)~~(24) "Subscribers" means those persons or groups of persons who contract with a
34 nonprofit medical service corporation for medical service pursuant to a nonprofit medical service

plan; and

~~(9)~~(25) "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)(1) Every ~~individual health insurance contract, plan, or policy~~ health benefit plan 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, 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. ~~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.~~

~~(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.~~

(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 or subscriber.

(3) A nonprofit medical service corporation shall not deny or restrict coverage for a child

1 who has not attained twenty-six (26) years of age based on the presence or absence of the child's
2 financial dependency upon the participant, primary subscriber or any other person, residency with
3 the participant and in the individual market the primary subscriber, or with any other person,
4 marital status, student status, employment or any combination of those factors. A nonprofit
5 medical service corporation shall not deny or restrict coverage of a child based on eligibility for
6 other coverage, except as provided in (b)(1) of this section.
7 (4) Nothing in this section shall be construed to require a health insurance carrier to make
8 coverage available for the child of a child receiving dependent coverage, unless the grandparent
9 becomes the legal guardian or adoptive parent of that grandchild.
10 (5) The terms of coverage in a health benefit plan offered by a nonprofit medical service
11 corporation or providing dependent coverage of children cannot vary based on age except for
12 children who are twenty-six (26) years of age or older.
13 (b)(1) For plan years beginning before January 1, 2014, a group health plan providing
14 group health insurance coverage that is a grandfathered health plan and makes available
15 dependent coverage of children may exclude an adult child who has not attained twenty-six (26)
16 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-
17 sponsored health benefit plan, as defined in section 5000A(f)(2) of the federal Internal Revenue
18 Code, other than the group health plan of a parent.
19 (2) For plan years, beginning on or after January 1, 2014, a health insurance carrier
20 providing group health insurance coverage that is a grandfathered health plan shall comply with
21 the requirements of this section.
22 (c)This section does not apply to insurance coverage providing benefits for: (1) hospital
23 confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare
24 supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other limited
25 benefit policies.
26 SECTION 8. Chapter 27-20 of the General laws entitled "Nonprofit Medical Service
27 Corporations" is hereby amended by adding thereto the following sections:
28 **27-20-6.1. Uniform explanation of benefits and coverage. –** (a) A nonprofit medical
29 service corporation shall provide a summary of benefits and coverage explanation and definitions
30 to policyholders and others required by, and at the times and in the format required, by the federal
31 regulations adopted under section 2715 of the Public Health Service Act, as amended by the
32 federal Affordable Care Act. The forms required by this section shall be made available to the
33 commissioner on request. Nothing in this section shall be construed to limit the authority of the
34 commissioner under existing state law.

1 (b) The provisions of this section shall apply to grandfathered health plans. This section
2 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
3 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6)
4 Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by
5 accident or both; and (9) Other limited benefit policies.
6 (c) If the commissioner of the office of the health insurance commissioner determines
7 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
8 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
9 an act of Congress, on the date of the commissioner's determination this section shall have its
10 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
11 section. Nothing in this section shall be construed to limit the authority of the commissioner
12 under existing state law.
13 **27-20-6.2. Filing of policy forms. –** A nonprofit medical service corporation shall file all
14 policy forms and rates used by it in the state with the commissioner, including the forms of any
15 rider, endorsement, application blank, and other matter generally used or incorporated by
16 reference in its policies or contracts of insurance. No such form shall be used if disapproved by
17 the commissioner under this section, or if the commissioner's approval has been withdrawn after
18 notice and an opportunity to be heard, or until the expiration of sixty (60) days following the
19 filing of the form. Such a company shall comply with its filed and approved and forms. If the
20 commissioner finds from an examination of any form that it is contrary to the public interest, or
21 the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and
22 shall notify the corporation in writing.
23 (b) Each rate filing shall include a certification by a qualified actuary that to the best of
24 the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws
25 and that the benefits offered or proposed to be offered are reasonable in relation to the premium
26 to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.
27
28 **27-20-57. Prohibition on preexisting condition exclusions. --** (a) A health insurance
29 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a
30 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:
31 (1) Shall not limit or exclude coverage for an individual under the age of nineteen (19) by
32 imposing a preexisting condition exclusion on that individual.
33 (2) For plan or policy years beginning on or after January 1, 2014, shall not limit or
34 exclude coverage for any individual by imposing a preexisting condition exclusion on that

1 individual.

2 (b) As used in this section:

3 (1) "Preexisting condition exclusion" means a limitation or exclusion of benefits,

4 including a denial of coverage, based on the fact that the condition (whether physical or mental)

5 was present before the effective date of coverage, or if the coverage is denied, the date of denial,

6 under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was

7 recommended or received before the effective date of coverage.

8 (2) "Preexisting condition exclusion" means any limitation or exclusion of benefits,

9 including a denial of coverage, applicable to an individual as a result of information relating to an

10 individual's health status before the individual's effective date of coverage, or if the coverage is

11 denied, the date of denial, under the health benefit plan, such as a condition (whether physical or

12 mental) identified as a result of a pre-enrollment questionnaire or physical examination given to

13 the individual, or review of medical records relating to the pre-enrollment period.

14 (c) This section shall not apply to grandfathered health plans providing individual health

15 insurance coverage.

16 (d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital

17 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)

18 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or

19 bodily injury or death by accident or both; and (9) Other limited benefit policies.

20 **27-20-58. Prohibition on rescission of coverage. –** (a)(1) Coverage under a health

21 benefit plan subject to the jurisdiction of the commissioner under this chapter with respect to an

22 individual, including a group to which the individual belongs or family coverage in which the

23 individual is included, shall not be subject to rescission after the individual is covered under the

24 plan, unless:

25 (A)The individual or a person seeking coverage on behalf of the individual, performs an

26 act, practice or omission that constitutes fraud; or

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

28 by the terms of the plan or coverage.

29 (2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an

30 individual does not include an insurance producer or employee or authorized representative of the

31 health carrier.

32 (b) At least thirty (30) days advance written notice shall be provided to each plan enrollee

33 or, for individual health insurance coverage, primary subscriber, who would be affected by the

34 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) This section applies to grandfathered health plans.

27-20-59. Annual and lifetime limits. – (a) Annual limits.

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

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

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

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

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

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

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

(b) Lifetime limits.

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

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

1 in accordance with federal laws and regulations.

2 (c)(1) Except as provided in subdivision (2) of this subsection, this section applies to any

3 health insurance carrier providing coverage under an individual or group health plan.

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

5 (B) The prohibition and limits on annual limits apply to grandfathered health plans

6 providing group health insurance coverage, but the prohibition and limits on annual limits do not

7 apply to grandfathered health plans providing individual health insurance coverage.

8 (d) This section shall not apply to a plan or to policy years prior to January 1, 2014 for

9 which the Secretary of the U.S. Department of Health and Human Services issued a waiver

10 pursuant to 45 C.F.R. §147.126(d)(3). This section also shall not apply to insurance coverage

11 providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident

12 only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified

13 disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other

14 limited benefit policies.

15 (e) If the commissioner of the office of the health insurance commissioner determines

16 that the corresponding provision of the federal Patient Protection and Affordable Care Act has

17 been declared invalid by a final judgment of the federal judicial branch or has been repealed by

18 an act of Congress, on the date of the commissioner's determination this section shall have its

19 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this

20 section. Nothing in this subsection shall be construed to limit the authority of the Commissioner

21 to regulate health insurance under existing state law.

22 **27-20-60. Coverage for individuals participating in approved clinical trials. –** (a) As

23 used in this section,

24 (1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial

25 that is conducted in relation to the prevention, detection or treatment of cancer or a life-

26 threatening disease or condition and is described in any of the following:

27 (A) The study or investigation is approved or funded, which may include funding through

28 in-kind contributions, by one or more of the following:

29 (i) The federal National Institutes of Health;

30 (ii) The federal Centers for Disease Control and Prevention;

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

32 (iv) The federal Centers for Medicare & Medicaid Services;

33 (v) A cooperative group or center of any of the entities described in items (i) through (iv)

34 or the U.S. Department of Defense or the U.S. Department of Veteran Affairs;

1 (vi) A qualified non-governmental research entity identified in the guidelines issued by
2 the federal National Institutes of Health for center support grants; or
3 (vii) A study or investigation conducted by the U.S. Department of Veteran Affairs, the
4 U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has
5 been reviewed and approved through a system of peer review that the Secretary of U.S.
6 Department of Health and Human Services determines:
7 (I) Is comparable to the system of peer review of studies and investigations used by the
8 federal National Institutes of Health; and
9 (II) Assures unbiased review of the highest scientific standards by qualified individuals
10 who have no interest in the outcome of the review.
11 (B) The study or investigation is conducted under an investigational new drug application
12 reviewed by the U.S. Food and Drug Administration; or
13 (C) The study or investigation is a drug trial that is exempt from having such an
14 investigational new drug application.
15 (2) "Participant" has the meaning stated in section 3(7) of federal ERISA.
16 (3) "Participating provider" means a health care provider that, under a contract with the
17 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
18 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
19 deductibles, directly or indirectly from the health carrier.
20 (4) "Qualified individual" means a participant or beneficiary who meets the following
21 conditions:
22 (A) The individual is eligible to participate in an approved clinical trial according to the
23 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;
24 and
25 (B)(i) The referring health care professional is a participating provider and has concluded
26 that the individual's participation in such trial would be appropriate based on the individual
27 meeting the conditions described in subdivision (A) of this subdivision (3); or
28 (ii) The participant or beneficiary provides medical and scientific information
29 establishing the individual's participation in such trial would be appropriate based on the
30 individual meeting the conditions described in subdivision (A) of this subdivision (3).
31 (5) "Life-threatening condition" means any disease or condition from which the
32 likelihood of death is probable unless the course of the disease or condition is interrupted.
33 (b)(1) If a health insurance carrier offering group or individual health insurance coverage
34 provides coverage to a qualified individual, the health carrier:

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

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

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

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

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

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

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

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

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

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

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

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

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

32 (d) This section shall not apply to grandfathered health plans. This section shall not apply
33 to insurance coverage providing benefits for: (1) Hospital confinement indemnity; (2) Disability
34 income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit

health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other limited benefit policies.

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

27-20-61. Medical loss ratio reporting and rebates. – (a) A nonprofit medical service corporation offering group or individual health insurance coverage of a health benefit plan, including a grandfathered health plan, shall comply with the provisions of Section 2718 of the Public Health Services Act as amended by the federal Affordable Care Act, in accordance with regulations adopted thereunder.

(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.

27-20-62. 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

1 services in the following manner:

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

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

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

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

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

12 (A) The exclusion of or coordination of benefits;

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

15 (C) Applicable cost-sharing.

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

26 (A) The amount negotiated with in-network providers for the emergency service
27 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
28 participant or beneficiary. If there is more than one amount negotiated with in-network providers
29 for the emergency service, the amount described under this subdivision (A) is the median of these
30 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
31 participant or beneficiary. In determining the median described in the preceding sentence, the
32 amount negotiated with each in-network provider is treated as a separate amount (even if the
33 same amount is paid to more than one provider). If there is no per-service amount negotiated with
34 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.

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

27-20-63. 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 only to those adverse benefit determinations which are not subject to the jurisdiction of the department of health pursuant to R.I. Gen. Laws § 23-17.12 et seq. (Utilization Review Act).

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

SECTION 9. 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 an individual'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 federal Patient Protection and Affordable Care act of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and federal regulations adopted thereunder;

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

(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.

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

(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.

(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

1 and each city and town in the state, which has in its employ one or more individuals during any
2 calendar year. For the purposes of this section, the term "employer" refers only to an employer
3 with persons employed within the state of Rhode Island.
4 (h) "Enrollee" means an individual who has been enrolled in a health maintenance
5 organization.
6 (i) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the
7 federal Affordable Care Act.
8 (j) "Evidence of coverage" means any certificate, agreement, or contract issued to an
9 enrollee setting out the coverage to which the enrollee is entitled.
10 (k) “Grandfathered health plan” means any group health plan or health insurance
11 coverage subject to 42 USC section 18011.
12 (l) “Group health insurance coverage” means, in connection with a group health plan,
13 health insurance coverage offered in connection with such plan.
14 (m) “Group health plan” means an employee welfare benefit plan as defined in 29 USC
15 section 1002(1), to the extent that the plan provides health benefits to employees or their
16 dependents directly or through insurance, reimbursement, or otherwise.
17 (n) “Health benefits” or “covered benefits” means coverage or benefits for the diagnosis,
18 cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting
19 any structure or function of the body including coverage or benefits for transportation primarily
20 for and essential thereto, and including medical services as defined in R.I. Gen. Laws § 27-19-17;
21 (o) “Health care facility” means an institution providing health care services or a health
22 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory
23 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,
24 laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
25 (p) "Health care professional" means a physician or other health care practitioner
26 licensed, accredited or certified to perform specified health care services consistent with state
27 law.
28 (q) "Health care provider" or "provider" means a health care professional or a health care
29 facility.
30 (r) "Health care services" means any services included in the furnishing to any individual
31 of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of that care or
32 hospitalization, and the furnishing to any person of any and all other services for the purpose of
33 preventing, alleviating, curing, or healing human illness, injury, or physical disability.
34 (s) “Health insurance carrier” means a person, firm, corporation or other entity subject to

1 the jurisdiction of the commissioner under this chapter, and includes a health maintenance

2 organization. Such term does not include a group health plan.

3 (t) "Health maintenance organization" means a single public or private organization

4 which:

5 (1) Provides or makes available to enrolled participants health care services, including at

6 least the following basic health care services: usual physician services, hospitalization, laboratory,

7 x-ray, emergency, and preventive services, and out of area coverage, and the services of licensed

8 midwives;

9 (2) Is compensated, except for copayments, for the provision of the basic health care

10 services listed in subdivision (1) of this subsection to enrolled participants on a predetermined

11 periodic rate basis; and

12 (3) Provides physicians' services primarily:

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

14 or

15 (B) Through arrangements with individual physicians or one or more groups of

16 physicians organized on a group practice or individual practice basis;

17 (ii) "Health maintenance organization" does not include prepaid plans offered by entities

18 regulated under chapter 1, 2, 19, or 20 of this title that do not meet the criteria above and do not

19 purport to be health maintenance organizations;

20 (4) Provides the services of licensed midwives primarily:

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

22 organization; or

23 (ii) Through arrangements with individual licensed midwives or one or more groups of

24 licensed midwives organized on a group practice or individual practice basis.

25 (u) "Licensed midwife" means any midwife licensed pursuant to section 23-13-9.

26 (v) "Material modification" means only systemic changes to the information filed under

27 section 27-41-3.

28 (w) "Net worth", for the purposes of this chapter, means the excess of total admitted

29 assets over total liabilities.

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

31 section 42-14.5-1 of the general laws.

32 (y) "Physician" includes podiatrist as defined in chapter 29 of title 5.

33 (z) "Private organization" means a legal corporation with a policy making and governing

34 body.

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

(bb) "Public organization" means an instrumentality of government.

(cc) "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.

(dd) "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.

(ee) "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.

(ff) "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~~ health benefit plan 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, 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. ~~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 policy holder 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, or 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 (b) (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) 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 federal 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 this section

(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 10. 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 summary of benefits and coverage explanation and definitions to policyholders and others required by, and at the times and in the format required, by the federal regulations adopted under section 2715 of the Public Health Service Act, as amended by the federal Affordable Care Act. The forms required by this section shall be made available to the commissioner on request. Nothing in this section shall be construed to limit the authority of the commissioner under existing state law.

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

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

27-41-29.2. Filing of policy forms. -- (a) 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 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. Such a company shall comply with its filed and approved 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.

(b) Each rate filing shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws and that the benefits offered or proposed to be offered are reasonable in relation to the premium to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

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:

1 (A) For a plan or policy year beginning after September 22, 2011, but before September
2 23, 2012 – one million two hundred fifty thousand dollars ($1,250,000); and
3 (B) For a plan or policy year beginning after September 22, 2012, but before January 1,
4 2014 – two million dollars ($2,000,000).
5 (2) For plan or policy years beginning on or after January 1, 2014, a health maintenance
6 organization shall not establish any annual limit on the dollar amount of essential health benefits
7 for any individual, except:
8 (A) A health flexible spending arrangement, as defined in section 106(c)(2)(i) of the
9 federal Internal Revenue Code, a medical savings account, as defined in section 220 of the federal
10 Internal Revenue Code, and a health savings account, as defined in section 223 of the federal
11 Internal Revenue Code are not subject to the requirements of subdivisions (1) and (2) of this
12 subsection .
13 (B) The provisions of this subsection shall not prevent a health maintenance organization
14 from placing annual dollar limits for any individual on specific covered benefits that are not
15 essential health benefits to the extent that such limits are otherwise permitted under applicable
16 federal law or the laws and regulations of this state.
17 (3) In determining whether an individual has received benefits that meet or exceed the
18 allowable limits, as provided in subdivision (1) of this subsection, a health maintenance
19 organization shall take into account only essential health benefits.
20 (b) Lifetime limits.
21 (1) A health insurance carrier and health benefit plan offering group or individual health
22 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
23 benefits for any individual.
24 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
25 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
26 benefits that are not essential health benefits in accordance with federal laws and regulations.
27 (c)(1) The provisions of this section relating to lifetime limits apply to any health
28 maintenance organization or health insurance carrier providing coverage under an individual or
29 group health plan, including grandfathered health plans.
30 (2) The provisions of this section relating to annual limits apply to any health
31 maintenance organization or health insurance carrier providing coverage under a group health
32 plan, including grandfathered health plans, but the prohibition and limits on annual limits do not
33 apply to grandfathered health plans providing individual health insurance coverage.
34 (d) This section shall not apply to a plan or to policy years prior to January 1, 2014 for

1 which the Secretary of the U.S. Department of Health and Human Services issued a waiver
2 pursuant to 45 C.F.R. § 147.126(d)(3). This section also shall not apply to insurance coverage
3 providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident
4 only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified
5 disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other
6 limited benefit policies.
7 (e) If the commissioner of the office of the health insurance commissioner determines
8 that the corresponding provision of the federal Patient Protection and Affordable Care Act has
9 been declared invalid by a final judgment of the federal judicial branch or has been repealed by
10 an act of Congress, on the date of the commissioner's determination this section shall have its
11 effectiveness suspended indefinitely, and the commissioner shall take no action to enforce this
12 section. Nothing in this subsection shall be construed to limit the authority of the Commissioner
13 to regulate health insurance under existing state law.
14 **27-41-77. Coverage for individual participating in approved clinical trials. --** (a) As
15 used in this section.
16 (1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial
17 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
18 threatening disease or condition and is described in any of the following:
19 (A) The study or investigation is approved or funded, which may include funding through
20 in-kind contributions, by one or more of the following:
21 (i) The federal National Institutes of Health;
22 (ii) The federal Centers for Disease Control and Prevention;
23 (iii) The federal Agency for Health Care Research and Quality;
24 (iv) The federal Centers for Medicare & Medicaid Services;
25 (v) A cooperative group or center of any of the entities described in items (i) through (iv)
26 or the U.S. Department of Defense or the U.S. Department of Veteran Affairs;
27 (vi) A qualified non-governmental research entity identified in the guidelines issued by
28 the federal National Institutes of Health for center support grants; or
29 (vii) A study or investigation conducted by the U.S. Department of Veteran Affairs, the
30 U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has
31 been reviewed and approved through a system of peer review that the Secretary of U.S.
32 Department of Health and Human Services determines:
33 (I) Is comparable to the system of peer review of studies and investigations used by the
34 federal National Institutes of Health; and

1 (II) Assures unbiased review of the highest scientific standards by qualified individuals
2 who have no interest in the outcome of the review.
3 (B) The study or investigation is conducted under an investigational new drug application
4 reviewed by the U.S. Food and Drug Administration; or
5 (C) The study or investigation is a drug trial that is exempt from having such an
6 investigational new drug application.
7 (2) "Participant" has the meaning stated in section 3(7) of federal ERISA.
8 (3) "Participating provider" means a health care provider that, under a contract with the
9 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
10 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
11 deductibles, directly or indirectly from the health carrier.
12 (4) "Qualified individual" means a participant or beneficiary who meets the following
13 conditions:
14 (A) The individual is eligible to participate in an approved clinical trial according to the
15 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;
16 and
17 (B)(i) The referring health care professional is a participating provider and has concluded
18 that the individual's participation in such trial would be appropriate based on the individual
19 meeting the conditions described in subdivision (A) of this subdivision (3); or
20 (ii) The participant or beneficiary provides medical and scientific information
21 establishing the individual's participation in such trial would be appropriate based on the
22 individual meeting the conditions described in subdivision (A) of this subdivision (3).
23 (5) "Life-threatening condition" means any disease or condition from which the
24 likelihood of death is probable unless the course of the disease or condition is interrupted.
25 (b)(1) If a health maintenance organization offering group or individual health insurance
26 coverage provides coverage to a qualified individual, it:
27 (A) Shall not deny the individual participation in an approved clinical trial.
28 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose
29 additional conditions on the coverage of routine patient costs for items and services furnished in
30 connection with participation in the approved clinical trial; and
31 (C) Shall not discriminate against the individual on the basis of the individual's
32 participation in the approved clinical trial.
33 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all
34 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.

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

27-41-78. Medical loss ratio reporting and rebates. -- (a) A health maintenance organization offering group or individual health insurance coverage of a health benefit plan, including a grandfathered health plan, shall comply with the provisions of Section 2718 of the Public Health Services Act as amended by the federal Affordable Care Act, in accordance with regulations adopted thereunder.

(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

1 Health and Human Services shall concurrently file such information with the commissioner.

2 **27-41-79. Emergency services. --** (a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

1 (A) The exclusion of or coordination of benefits;

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

4 (C) Applicable cost sharing.

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

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

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

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

34 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement

1 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
2 services provided out of network if the cost-sharing requirement generally applies to out-of-
3 network benefits. A deductible may be imposed with respect to out-of-network emergency
4 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
5 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
6 apply to out-of-network emergency services.
7 (e) The provisions of this section apply for plan years beginning on or after September
8 23, 2010.
9 (f) The provisions of this section shall apply to grandfathered health plans. This section
10 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
11 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6)
12 Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by
13 accident or both; and (9) Other limited benefit policies.
14 **27-41-80. Internal and external appeal of adverse benefit determinations. --** (a) The
15 commissioner shall adopt regulations to implement standards and procedures with respect to
16 internal claims and appeals of adverse benefit determinations, and with respect to external appeals
17 of adverse benefit determinations.
18 (b) The regulations adopted by the commissioner shall apply only to those adverse
19 benefit determinations within the jurisdiction of the department of health pursuant to R.I. Gen.
20 Laws § 23-17.12 et seq. (Utilization Review Act).
21 (c) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
22 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
23 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
24 bodily injury or death by accident or both; and (9) Other limited benefit policies. This section also
25 shall not apply to grandfathered health plans.
26 **27-41-81. Prohibition on preexisting condition exclusions. --** (a) A health insurance
27 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a
28 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:
29 (1) Shall not limit or exclude coverage for an individual under the age of nineteen (19) by
30 imposing a preexisting condition exclusion on that individual.
31 (2) For plan or policy years beginning on or after January 1, 2014, shall not limit or
32 exclude coverage for any individual by imposing a preexisting condition exclusion on that
33 individual.
34 (b) As used in this section:

1 (1) "Preexisting condition exclusion" means a limitation or exclusion of benefits,
2 including a denial of coverage, based on the fact that the condition (whether physical or mental)
3 was present before the effective date of coverage, or if the coverage is denied, the date of denial,
4 under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was
5 recommended or received before the effective date of coverage.
6 (2) "Preexisting condition exclusion" means any limitation or exclusion of benefits,
7 including a denial of coverage, applicable to an individual as a result of information relating to an
8 individual's health status before the individual's effective date of coverage, or if the coverage is
9 denied, the date of denial, under the health benefit plan, such as a condition (whether physical or
10 mental) identified as a result of a pre-enrollment questionnaire or physical examination given to
11 the individual, or review of medical records relating to the pre-enrollment period.
12 (c) This section shall not apply to grandfathered health plans providing individual health
13 insurance coverage.
14 (d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
15 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
16 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
17 bodily injury or death by accident or both; and (9) Other limited benefit policies.
18 SECTION 11. Sections 27-50-3 and 27-50-7 of the General Laws in Chapter 27-50
19 entitled "Small Employer Health Insurance Availability Act" are hereby amended to read as
20 follows:
21 **27-50-3. Definitions. [Effective December 31, 2010.] --** (a) "Actuarial certification"
22 means a written statement signed by a member of the American Academy of Actuaries or other
23 individual acceptable to the director that a small employer carrier is in compliance with the
24 provisions of section 27-50-5, based upon the person's examination and including a review of the
25 appropriate records and the actuarial assumptions and methods used by the small employer carrier
26 in establishing premium rates for applicable health benefit plans.
27 (b) "Adjusted community rating" means a method used to develop a carrier's premium
28 which spreads financial risk across the carrier's entire small group population in accordance with
29 the requirements in section 27-50-5.
30 (c) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
31 through one or more intermediaries controls or is controlled by, or is under common control with,
32 a specified entity or person.
33 (d) "Affiliation period" means a period of time that must expire before health insurance
34 coverage provided by a carrier becomes effective, and during which the carrier is not required to

provide benefits.

(e) "Bona fide association" means, with respect to health benefit plans offered in this state, an association which:

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

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

(3) Does not condition membership in the association on any health-status related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to those members (or individuals eligible for coverage through a member);

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

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

(7) Has a constitution and bylaws; and

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

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

(g) "Church plan" has the meaning given this term under section 3(33) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. section 1002(33)_.

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

(i) (1) "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

(i) A group health plan;

(ii) A health benefit plan;

(iii) Part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. section 1395c et seq., or 42 U.S.C. section 1395j et seq., (Medicare);

(iv) Title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq., (Medicaid), other than coverage consisting solely of benefits under 42 U.S.C. section 1396s (the program for distribution of pediatric vaccines);

(v) 10 U.S.C. section 1071 et seq., (medical and dental care for members and certain former members of the uniformed services, and for their dependents)(Civilian Health and Medical Program of the Uniformed Services)(CHAMPUS). For purposes of 10 U.S.C. section 1071 et seq., "uniformed services" means the armed forces and the commissioned corps of the National Oceanic and Atmospheric Administration and of the Public Health Service;

(vi) A medical care program of the Indian Health Service or of a tribal organization;

(vii) A state health benefits risk pool;

(viii) A health plan offered under 5 U.S.C. section 8901 et seq., (Federal Employees Health Benefits Program (FEHBP));

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

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

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

(j) "Dependent" means a spouse, ~~an unmarried~~ child under the age ~~of nineteen (19)~~ twenty-six (26) years, ~~an unmarried child who is a student under the age of twenty five (25) years,~~ and an unmarried child of any age who is financially dependent upon, the parent and is medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

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

(l) [Deleted by P.L. 2006, ch. 258, section 2, and P.L. 2006, ch. 296, section 2.]

(m) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the term shall also include an employee who works on a full-time basis with a normal work week of

1 anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this
2 eligibility criterion is applied uniformly among all of the employer's employees and without
3 regard to any health status-related factor. The term includes a self-employed individual, a sole
4 proprietor, a partner of a partnership, and may include an independent contractor, if the self-
5 employed individual, sole proprietor, partner, or independent contractor is included as an
6 employee under a health benefit plan of a small employer, but does not include an employee who
7 works on a temporary or substitute basis or who works less than seventeen and one-half (17.5)
8 hours per week. Any retiree under contract with any independently incorporated fire district is
9 also included in the definition of eligible employee, as well as any former employee of an
10 employer who retired before normal retirement age, as defined by 42 U.S.C. 18002(a)(2)(c) while
11 the employer participates in the early retiree reinsurance program defined by that chapter. Persons
12 covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation
13 Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation
14 requirements pursuant to section 27-50-7(d)(9).
15 (n) "Enrollment date" means the first day of coverage or, if there is a waiting period, the
16 first day of the waiting period, whichever is earlier.
17 (o) "Established geographic service area" means a geographic area, as approved by the
18 director and based on the carrier's certificate of authority to transact insurance in this state, within
19 which the carrier is authorized to provide coverage.
20 (p) "Family composition" means:
21 (1) Enrollee;
22 (2) Enrollee, spouse and children;
23 (3) Enrollee and spouse; or
24 (4) Enrollee and children.
25 (q) "Genetic information" means information about genes, gene products, and inherited
26 characteristics that may derive from the individual or a family member. This includes information
27 regarding carrier status and information derived from laboratory tests that identify mutations in
28 specific genes or chromosomes, physical medical examinations, family histories, and direct
29 analysis of genes or chromosomes.
30 (r) "Governmental plan" has the meaning given the term under section 3(32) of the
31 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(32), and any federal
32 governmental plan.
33 (s) (1) "Group health plan" means an employee welfare benefit plan as defined in section
34 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the

1 extent that the plan provides medical care, as defined in subsection (y) of this section, and
2 including items and services paid for as medical care to employees or their dependents as defined
3 under the terms of the plan directly or through insurance, reimbursement, or otherwise.
4 (2) For purposes of this chapter:
5 (i) Any plan, fund, or program that would not be, but for PHSA Section 2721(e), 42
6 U.S.C. section 300gg(e), as added by P.L. 104-191, an employee welfare benefit plan and that is
7 established or maintained by a partnership, to the extent that the plan, fund or program provides
8 medical care, including items and services paid for as medical care, to present or former partners
9 in the partnership, or to their dependents, as defined under the terms of the plan, fund or program,
10 directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph
11 (ii) of this subdivision, as an employee welfare benefit plan that is a group health plan;
12 (ii) In the case of a group health plan, the term "employer" also includes the partnership
13 in relation to any partner; and
14 (iii) In the case of a group health plan, the term "participant" also includes an individual
15 who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary
16 who is, or may become, eligible to receive a benefit under the plan, if:
17 (A) In connection with a group health plan maintained by a partnership, the individual is
18 a partner in relation to the partnership; or
19 (B) In connection with a group health plan maintained by a self-employed individual,
20 under which one or more employees are participants, the individual is the self-employed
21 individual.
22 (t) (1) "Health benefit plan" means any hospital or medical policy or certificate, major
23 medical expense insurance, hospital or medical service corporation subscriber contract, or health
24 maintenance organization subscriber contract. Health benefit plan includes short-term and
25 catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as
26 otherwise specifically exempted in this definition.
27 (2) "Health benefit plan" does not include one or more, or any combination of, the
28 following:
29 (i) Coverage only for accident or disability income insurance, or any combination of
30 those;
31 (ii) Coverage issued as a supplement to liability insurance;
32 (iii) Liability insurance, including general liability insurance and automobile liability
33 insurance;
34 (iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

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

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

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

(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 of those; or

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

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

following:

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

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

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

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

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

(1) Health status;

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

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

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

(8) Disability.

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

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

(i) Who meets each of the following provisions:

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

(B) The individual lost creditable coverage as a result of cessation of employer contribution, termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of creditable coverage, or death of a spouse, divorce or

legal separation, or the individual and/or dependents are determined to be eligible for RIteCare under chapter 5.1 of title 40 or chapter 12.3 of title 42 or for RIteShare under chapter 8.4 of title 40; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (bb) "Plan sponsor" has the meaning given this term under section 3(16)(B) of the
2 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(16)(B).
3 (cc) (1) "Preexisting condition" means a condition, regardless of the cause of the
4 condition, for which medical advice, diagnosis, care, or treatment was recommended or received
5 during the six (6) months immediately preceding the enrollment date of the coverage.
6 (2) "Preexisting condition" does not mean a condition for which medical advice,
7 diagnosis, care, or treatment was recommended or received for the first time while the covered
8 person held creditable coverage and that was a covered benefit under the health benefit plan,
9 provided that the prior creditable coverage was continuous to a date not more than ninety (90)
10 days prior to the enrollment date of the new coverage.
11 (3) Genetic information shall not be treated as a condition under subdivision (1) of this
12 subsection for which a preexisting condition exclusion may be imposed in the absence of a
13 diagnosis of the condition related to the information.
14 (dd) "Premium" means all moneys paid by a small employer and eligible employees as a
15 condition of receiving coverage from a small employer carrier, including any fees or other
16 contributions associated with the health benefit plan.
17 (ee) "Producer" means any insurance producer licensed under chapter 2.4 of this title.
18 (ff) "Rating period" means the calendar period for which premium rates established by a
19 small employer carrier are assumed to be in effect.
20 (gg) "Restricted network provision" means any provision of a health benefit plan that
21 conditions the payment of benefits, in whole or in part, on the use of health care providers that
22 have entered into a contractual arrangement with the carrier pursuant to provide health care
23 services to covered individuals.
24 (hh) "Risk adjustment mechanism" means the mechanism established pursuant to section
25 27-50-16.
26 (ii) "Self-employed individual" means an individual or sole proprietor who derives a
27 substantial portion of his or her income from a trade or business through which the individual or
28 sole proprietor has attempted to earn taxable income and for which he or she has filed the
29 appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.
30 (jj) "Significant break in coverage" means a period of ninety (90) consecutive days
31 during all of which the individual does not have any creditable coverage, except that neither a
32 waiting period nor an affiliation period is taken into account in determining a significant break in
33 coverage.
34 (kk) "Small employer" means, except for its use in section 27-50-7, any person, firm,

corporation, partnership, association, political subdivision, or self-employed individual that is actively engaged in business including, but not limited to, a business or a corporation organized under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of another state that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week of thirty (30) or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term small employer includes a self-employed individual.

(ll) "Waiting period" means, with respect to a group health plan and an individual who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to subsection (j)(2) of this section, a waiting period shall not be considered a gap in coverage.

(mm) "Wellness health benefit plan" means a plan developed pursuant to section 27-50-10.

(nn) "Health insurance commissioner" or "commissioner" means that individual appointed pursuant to section 42-14.5-1 of the general laws and afforded those powers and duties as set forth in sections 42-14.5-2 and 42-14.5-3 of title 42.

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

(pp) "Wellness health benefit plan" means the health benefit plan offered by each small employer carrier pursuant to section 27-50-7.

(qq) "Commissioner" means the health insurance commissioner.

27-50-7. Availability of coverage. -- (a) Until October 1, 2004, for purposes of this section, "small employer" includes any person, firm, corporation, partnership, association, or political subdivision that is actively engaged in business that on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed a combination of no more than

1 fifty (50) and no less than two (2) eligible employees and part-time employees, the majority of
2 whom were employed within this state, and is not formed primarily for purposes of buying health
3 insurance and in which a bona fide employer-employee relationship exists. After October 1, 2004,
4 for the purposes of this section, "small employer" has the meaning used in section 27-50-3(kk).
5 (b) (1) Every small employer carrier shall, as a condition of transacting business in this
6 state with small employers, actively offer to small employers all health benefit plans it actively
7 markets to small employers in this state including a wellness health benefit plan. A small
8 employer carrier shall be considered to be actively marketing a health benefit plan if it offers that
9 plan to any small employer not currently receiving a health benefit plan from the small employer
10 carrier.
11 (2) Subject to subdivision (1) of this subsection, a small employer carrier shall issue any
12 health benefit plan to any eligible small employer that applies for that plan and agrees to make the
13 required premium payments and to satisfy the other reasonable provisions of the health benefit
14 plan not inconsistent with this chapter. However, no carrier is required to issue a health benefit
15 plan to any self-employed individual who is covered by, or is eligible for coverage under, a health
16 benefit plan offered by an employer.
17 (c) (1) A small employer carrier shall file with the director, in a format and manner
18 prescribed by the director, the health benefit plans to be used by the carrier. A health benefit plan
19 filed pursuant to this subdivision may be used by a small employer carrier beginning thirty (30)
20 days after it is filed unless the director disapproves its use.
21 (2) The director may at any time may, after providing notice and an opportunity for a
22 hearing to the small employer carrier, disapprove the continued use by a small employer carrier of
23 a health benefit plan on the grounds that the plan does not meet the requirements of this chapter.
24 (d) Health benefit plans covering small employers shall comply with the following
25 provisions:
26 (1) A health benefit plan shall not deny, exclude, or limit benefits for a covered
27 individual for losses incurred more than six (6) months following the enrollment date of the
28 individual's coverage due to a preexisting condition, or the first date of the waiting period for
29 enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a
30 preexisting condition more restrictively than as defined in section 27-50-3.
31 (2) (i) Except as provided in subdivision (3) of this subsection, a small employer carrier
32 shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of
33 creditable coverage without regard to the specific benefits covered during the period of creditable
34 coverage, provided that the last period of creditable coverage ended on a date not more than

1 ninety (90) days prior to the enrollment date of new coverage.
2 (ii) The aggregate period of creditable coverage does not include any waiting period or
3 affiliation period for the effective date of the new coverage applied by the employer or the carrier,
4 or for the normal application and enrollment process following employment or other triggering
5 event for eligibility.
6 (iii) A carrier that does not use preexisting condition limitations in any of its health
7 benefit plans may impose an affiliation period that:
8 (A) Does not exceed sixty (60) days for new entrants and not to exceed ninety (90) days
9 for late enrollees;
10 (B) During which the carrier charges no premiums and the coverage issued is not
11 effective; and
12 (C) Is applied uniformly, without regard to any health status-related factor.
13 (iv) This section does not preclude application of any waiting period applicable to all
14 new enrollees under the health benefit plan, provided that any carrier-imposed waiting period is
15 no longer than sixty (60) days.
16 (3) (i) Instead of as provided in paragraph (2)(i) of this subsection, a small employer
17 carrier may elect to reduce the period of any preexisting condition exclusion based on coverage of
18 benefits within each of several classes or categories of benefits specified in federal regulations.
19 (ii) A small employer electing to reduce the period of any preexisting condition
20 exclusion using the alternative method described in paragraph (i) of this subdivision shall:
21 (A) Make the election on a uniform basis for all enrollees; and
22 (B) Count a period of creditable coverage with respect to any class or category of
23 benefits if any level of benefits is covered within the class or category.
24 (iii) A small employer carrier electing to reduce the period of any preexisting condition
25 exclusion using the alternative method described under paragraph (i) of this subdivision shall:
26 (A) Prominently state that the election has been made in any disclosure statements
27 concerning coverage under the health benefit plan to each enrollee at the time of enrollment under
28 the plan and to each small employer at the time of the offer or sale of the coverage; and
29 (B) Include in the disclosure statements the effect of the election.
30 (4) (i) A health benefit plan shall accept late enrollees, but may exclude coverage for late
31 enrollees for preexisting conditions for a period not to exceed twelve (12) months.
32 (ii) A small employer carrier shall reduce the period of any preexisting condition
33 exclusion pursuant to subdivision (2) or (3) of this subsection.
34 (5) A small employer carrier shall not impose a preexisting condition exclusion:

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

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

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

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

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

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

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

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

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

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

1 (ii) If an employee requests enrollment pursuant to subparagraph (i)(D) of this
2 subdivision, the enrollment is effective not later than the first day of the first calendar month
3 beginning after the date the completed request for enrollment is received.
4 (8) (i) A small employer carrier that makes coverage available under a group health plan
5 with respect to a dependent of an individual shall provide for a dependent special enrollment
6 period described in paragraph (ii) of this subdivision during which the person or, if not enrolled,
7 the individual may be enrolled under the group health plan as a dependent of the individual and,
8 in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a
9 dependent of the individual if the spouse is eligible for coverage if:
10 (A) The individual is a participant under the health benefit plan or has met any waiting
11 period applicable to becoming a participant under the plan and is eligible to be enrolled under the
12 plan, but for a failure to enroll during a previous enrollment period; and
13 (B) A person becomes a dependent of the individual through marriage, birth, or adoption
14 or placement for adoption.
15 (ii) The special enrollment period for individuals that meet the provisions of paragraph
16 (i) of this subdivision is a period of not less than thirty (30) days and begins on the later of:
17 (A) The date dependent coverage is made available; or
18 (B) The date of the marriage, birth, or adoption or placement for adoption described in
19 subparagraph (i)(B) of this subdivision.
20 (iii) If an individual seeks to enroll a dependent during the first thirty (30) days of the
21 dependent special enrollment period described under paragraph (ii) of this subdivision, the
22 coverage of the dependent is effective:
23 (A) In the case of marriage, not later than the first day of the first month beginning after
24 the date the completed request for enrollment is received;
25 (B) In the case of a dependent's birth, as of the date of birth; and
26 (C) In the case of a dependent's adoption or placement for adoption, the date of the
27 adoption or placement for adoption.
28 (9) (i) Except as provided in this subdivision, requirements used by a small employer
29 carrier in determining whether to provide coverage to a small employer, including requirements
30 for minimum participation of eligible employees and minimum employer contributions, shall be
31 applied uniformly among all small employers applying for coverage or receiving coverage from
32 the small employer carrier.
33 (ii) For health benefit plans issued or renewed on or after October 1, 2000, a small
34 employer carrier shall not require a minimum participation level greater than seventy-five percent

1 (75%) of eligible employees.

2 (iii) In applying minimum participation requirements with respect to a small employer, a
3 small employer carrier shall not consider employees or dependents who have creditable coverage
4 in determining whether the applicable percentage of participation is met.

5 (iv) A small employer carrier shall not increase any requirement for minimum employee
6 participation or modify any requirement for minimum employer contribution applicable to a small
7 employer at any time after the small employer has been accepted for coverage.

8 (10) (i) If a small employer carrier offers coverage to a small employer, the small
9 employer carrier shall offer coverage to all of the eligible employees of a small employer and
10 their dependents who apply for enrollment during the period in which the employee first becomes
11 eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to
12 only certain individuals or dependents in a small employer group or to only part of the group.

13 (ii) A small employer carrier shall not place any restriction in regard to any health status-
14 related factor on an eligible employee or dependent with respect to enrollment or plan
15 participation.

16 (iii) Except as permitted under subdivisions (1) and (4) of this subsection, a small
17 employer carrier shall not modify a health benefit plan with respect to a small employer or any
18 eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude
19 coverage or benefits for specific diseases, medical conditions, or services covered by the plan.

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

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

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

27 (iii) Within an area where the small employer carrier reasonably anticipates, and
28 demonstrates to the satisfaction of the director, that it will not have the capacity within its
29 established geographic service area to deliver services adequately to enrollees of any additional
30 groups because of its obligations to existing group policyholders and enrollees.

31 (2) A small employer carrier that cannot offer coverage pursuant to paragraph (1)(iii) of
32 this subsection may not offer coverage in the applicable area to new cases of employer groups
33 until the later of one hundred and eighty (180) days following each refusal or the date on which
34 the carrier notifies the director that it has regained capacity to deliver services to new employer

1 groups.

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

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

8 (i) For any period of time the director determines the small employer carrier does not
9 have the financial reserves necessary to underwrite additional coverage; and

10 (ii) The small employer carrier is applying this subsection uniformly to all small
11 employers in the small group market in this state consistent with applicable state law and without
12 regard to the claims experience of a small employer and its employees and their dependents or
13 any health status-related factor relating to the employees and their dependents.

14 (2) A small employer carrier that denies coverage in accordance with subdivision (1) of
15 this subsection may not offer coverage in the small group market for the later of:

16 (i) A period of one hundred and eighty (180) days after the date the coverage is denied;
17 or

18 (ii) Until the small employer has demonstrated to the director that it has sufficient
19 financial reserves to underwrite additional coverage.

20 (g) (1) A small employer carrier is not required to provide coverage to small employers
21 pursuant to subsection (b) of this section if the small employer carrier elects not to offer new
22 coverage to small employers in this state.

23 (2) A small employer carrier that elects not to offer new coverage to small employers
24 under this subsection may be allowed, as determined by the director, to maintain its existing
25 policies in this state.

26 (3) A small employer carrier that elects not to offer new coverage to small employers
27 under subdivision (g)(1) shall provide at least one hundred and twenty (120) days notice of its
28 election to the director and is prohibited from writing new business in the small employer market
29 in this state for a period of five (5) years beginning on the date the carrier ceased offering new
30 coverage in this state.

31 (h) No small group carrier may impose a pre-existing condition exclusion pursuant to the
32 provisions of subdivisions 27-50-7(d)(1), 27-50-7(d)(2), 27-50-7(d)(3), 27-50-7(d)(4), 27-50-
33 7(d)(5) and 27-50-7(d)(6) with regard to an individual that is less than nineteen (19) years of age.
34 With respect to health benefit plans issued on and after January 1, 2014 a small employer carrier

shall offer and issue coverage to small employers and eligible individuals notwithstanding any pre-existing condition of an employee, member, or individual, or their dependents.

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

27-18.6-3. Limitation on preexisting condition exclusion. -- (a) (1) Notwithstanding any of the provisions of this title to the contrary, a group health plan and a health insurance carrier offering group health insurance coverage shall not deny, exclude, or limit benefits with respect to a participant or beneficiary because of a preexisting condition exclusion except if:

(i) The exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date;

(ii) The exclusion extends for a period of not more than twelve (12) months (or eighteen (18) months in the case of a late enrollee) after the enrollment date; and

(iii) The period of the preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or the beneficiary as of the enrollment date.

(2) For purposes of this section, genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information.

(b) With respect to paragraph (a)(1)(iii) of this section, a period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after that period and before the enrollment date, there was a sixty-three (63) day period during which the individual was not covered under any creditable coverage.

(c) Any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance or is in an affiliation period shall not be taken into account in determining the continuous period under subsection (b) of this section.

(d) Except as otherwise provided in subsection (e) of this section, for purposes of applying paragraph (a)(1)(iii) of this section, a group health plan and a health insurance carrier offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(e) (1) A group health plan or a health insurance carrier offering group health insurance may elect to apply paragraph (a)(1)(iii) of this section based on coverage of benefits within each of several classes or categories of benefits. Those classes or categories of benefits are to be determined by the secretary of the United States Department of Health and Human Services pursuant to regulation. The election shall be made on a uniform basis for all participants and

beneficiaries. Under the election, a group health plan or carrier shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(2) In the case of an election under this subsection with respect to a group health plan (whether or not health insurance coverage is provided in connection with that plan), the plan shall:

(i) Prominently state in any disclosure statements concerning the plan, and state to each enrollee under the plan, that the plan has made the election; and

(ii) Include in the statements a description of the effect of this election.

(3) In the case of an election under this subsection with respect to health insurance coverage offered by a carrier in the large group market, the carrier shall:

(i) Prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the carrier has made the election; and

(ii) Include in the statements a description of the effect of the election.

(f) (1) A group health plan and a health insurance carrier offering group health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty (30) day period beginning with the date of birth, is covered under creditable coverage.

(2) Subdivision (1) of this subsection shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any creditable coverage. Moreover, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period for purposes of determining creditable coverage.

(g) (1) A group health plan and a health insurance carrier offering group health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, as of the last day of the thirty (30) day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(2) Subdivision (1) of this subsection shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any creditable coverage. Any period that an individual is in a waiting period for any coverage

1 under a group health plan (or for group health insurance coverage) or is in an affiliation period
2 shall not be taken into account in determining the continuous period for purposes of determining
3 creditable coverage.
4 (h) A group health plan and a health insurance carrier offering group health insurance
5 coverage may not impose any preexisting condition exclusion relating to pregnancy as a
6 preexisting condition or with regard to an individual who is under nineteen (19) years of age.
7 (i) (1) Periods of creditable coverage with respect to an individual shall be established
8 through presentation of certifications. A group health plan and a health insurance carrier offering
9 group health insurance coverage shall provide certifications:
10 (i) At the time an individual ceases to be covered under the plan or becomes covered
11 under a COBRA continuation provision;
12 (ii) In the case of an individual becoming covered under a continuation provision, at the
13 time the individual ceases to be covered under that provision; and
14 (iii) On the request of an individual made not later than twenty-four (24) months after the
15 date of cessation of the coverage described in paragraph (i) or (ii) of this subdivision, whichever
16 is later.
17 (2) The certification under this subsection may be provided, to the extent practicable, at a
18 time consistent with notices required under any applicable COBRA continuation provision.
19 (3) The certification described in this subsection is a written certification of:
20 (i) The period of creditable coverage of the individual under the plan and the coverage (if
21 any) under the COBRA continuation provision; and
22 (ii) The waiting period (if any) (and affiliation period, if applicable) imposed with respect
23 to the individual for any coverage under the plan.
24 (4) To the extent that medical care under a group health plan consists of group health
25 insurance coverage, the plan is deemed to have satisfied the certification requirement under this
26 subsection if the health insurance carrier offering the coverage provides for the certification in
27 accordance with this subsection.
28 (5) In the case of an election taken pursuant to subsection (e) of this section by a group
29 health plan or a health insurance carrier, if the plan or carrier enrolls an individual for coverage
30 under the plan and the individual provides a certification of creditable coverage, upon request of
31 the plan or carrier, the entity which issued the certification shall promptly disclose to the
32 requisition plan or carrier information on coverage of classes and categories of health benefits
33 available under that entity's plan or coverage, and the entity may charge the requesting plan or
34 carrier for the reasonable cost of disclosing the information.

1 (6) Failure of an entity to provide information under this subsection with respect to
2 previous coverage of an individual so as to adversely affect any subsequent coverage of the
3 individual under another group health plan or health insurance coverage, as determined in
4 accordance with rules and regulations established by the secretary of the United States
5 Department of Health and Human Services, is a violation of this chapter.
6 (j) A group health plan and a health insurance carrier offering group health insurance
7 coverage in connection with a group health plan shall permit an employee who is eligible, but not
8 enrolled, for coverage under the terms of the plan (or a dependent of an employee if the
9 dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under
10 the terms of the plan if each of the following conditions are met:
11 (1) The employee or dependent was covered under a group health plan or had health
12 insurance coverage at the time coverage was previously offered to the employee or dependent;
13 (2) The employee stated in writing at the time that coverage under a group health plan or
14 health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or
15 carrier (if applicable) required a statement at the time and provided the employee with notice of
16 that requirement (and the consequences of the requirement) at the time;
17 (3) The employee's or dependent's coverage described in subsection (j)(1):
18 (i) Was under a COBRA continuation provision and the coverage under that provision
19 was exhausted; or
20 (ii) Was not under a continuation provision and either the coverage was terminated as a
21 result of loss of eligibility for the coverage (including as a result of legal separation, divorce,
22 death, termination of employment, or reduction in the number of hours of employment) or
23 employer contributions towards the coverage were terminated; and
24 (4) Under the terms of the plan, the employee requests enrollment not later than thirty
25 (30) days after the date of exhaustion of coverage described in paragraph (3)(i) of this subsection
26 or termination of coverage or employer contribution described in paragraph (3)(ii) of this
27 subsection.
28 (k) (1) If a group health plan makes coverage available with respect to a dependent of an
29 individual, the individual is a participant under the plan (or has met any waiting period applicable
30 to becoming a participant under the plan and is eligible to be enrolled under the plan but for a
31 failure to enroll during a previous enrollment period), and a person becomes a dependent of the
32 individual through marriage, birth, or adoption or placement through adoption, the group health
33 plan shall provide for a dependent special enrollment period during which the person (or, if not
34 enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in

the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is eligible for coverage.

(2) A dependent special enrollment period shall be a period of not less than thirty (30) days and shall begin on the later of:

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

(ii) The date of the marriage, birth, or adoption or placement for adoption (as the case may be).

(3) If an individual seeks to enroll a dependent during the first thirty (30) days of a dependent special enrollment period, the coverage of the dependent shall become effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent's birth, as of the date of the birth; or

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

(l) (1) A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for the coverage option, but only if that period is applied uniformly without regard to any health status-related factors, and the period does not exceed two (2) months (or three (3) months in the case of a late enrollee).

(2) For the purposes of this subsection, an affiliation shall begin on the enrollment date.

(3) An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(4) The director may approve alternative methods from those described under this subsection to address adverse selection.

(m) For the purpose of determining creditable coverage pursuant to this chapter, no period before July 1, 1996, shall be taken into account. Individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have the coverage credited but for the prohibition in the preceding sentence may be given credit for creditable coverage for those periods through the presentation of documents or other means in accordance with any rule or regulation that may be established by the secretary of the United States Department of Health and Human Services.

(n) In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30,

1996, the individual may present other credible evidence of coverage in order to establish the period of creditable coverage. The group health plan and a health insurance carrier shall not be subject to any penalty or enforcement action with respect to the plan's or carrier's crediting (or not crediting) the coverage if the plan or carrier has sought to comply in good faith with the applicable requirements of this section.

(o) Notwithstanding the provisions of any general or public law to the contrary, for plan or policy years beginning on and after January 1, 2014, a group health plan and a health insurance carrier offering group health insurance coverage shall not deny, exclude, or limit benefits with respect to a participant or beneficiary because of a preexisting condition exclusion.

SECTION. 13 Applicability and Construction.

(a) This act shall apply only to health insurance policies, subscriber contracts, and any other health benefit contract issued on and after July 1, 2012 notwithstanding any other provision of this act.

(b) In its construction and enforcement of the provisions of this act, and in the interests of promoting uniform national rules for health insurance carriers, the office of the health insurance commissioner shall give due deference to the construction, enforcement policies, and guidance of the federal government with respect to federal law substantially similar to the provisions of this act.

SECTION 14. Sections 27-18-36, 27-18-36.1, 27-18-36.2 and 27-18-36.3 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" are hereby repealed on the effective date of RI General Law 27-18-80.

~~**27-18-36. New cancer therapies -- Under investigation. --** Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state, except policies which only provide coverage for specified diseases other than cancer, fixed indemnity, disability income, accident only, long-term care Medicare supplement limited benefit health, sickness or bodily injury or death by accident or both, or other limited benefit policies, shall provide coverage for new cancer therapies still under investigation as outlined in this chapter.~~

~~**27-18-36.1. "Reliable evidence" defined. --** "Reliable evidence" means:~~

~~(1) Evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature;~~

~~(2) A written informed consent used by the treating facility or by another facility studying substantially the same service; or~~

~~(3) A written protocol or protocols used by the treating facility or protocols of another~~

~~facility studying substantially the same service.~~

~~**27-18-36.2. Conditions of coverage. --** As provided in section 27-18-36, coverage shall be extended to new cancer therapies still under investigation when the following circumstances are present:~~

~~(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI), Community clinical oncology programs; the Food and Drug Administration in the form of an Investigational New Drug (IND) exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;~~

~~(2) The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);~~

~~(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;~~

~~(4) The patients receiving the investigational treatment meet all protocol requirements;~~

~~(5) There is no clearly superior, noninvestigational alternative to the protocol treatment;~~

~~(6) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the noninvestigational alternative; and~~

~~(7) The coverage of new cancer therapy treatment provided pursuant to a Phase II clinical trial shall not be required for only that portion of that treatment provided as part of the phase II clinical trial and is otherwise funded by a national agency, such as the National Cancer Institute, the Veteran's Administration, the Department of Defense, or funded by commercial organizations such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any portions of a Phase II trial which are customarily funded by government, biotechnical and/or pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall continue to be so funded in Rhode Island and coverage pursuant to this section shall supplement, not supplant, customary funding.~~

~~**27-18-36.3. Managed care. --** Nothing in this chapter shall preclude the conducting of managed care reviews and medical necessity reviews by an insurer, hospital or medical service corporation, or health maintenance organization.~~

SECTION 15. Sections 27-19-32, 27-19-32.1, 27-19-32.2 and 27-19-32.3 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" are hereby repealed on the effective date of RI General Law 27-19-64.

~~**27-19-32. New cancer therapies -- Under investigation. --** Every individual or group~~

~~hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state shall provide coverage for new cancer therapies still under investigation as outlined in this chapter.~~

~~**27-19-32.1. "Reliable evidence" defined. --** "Reliable evidence" means:~~

~~(1) Evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature;~~

~~(2) A written informed consent used by the treating facility or by another facility studying substantially the same service; or~~

~~(3) A written protocol or protocols used by the treating facility or protocols of another facility studying substantially the same service.~~

~~**27-19-32.2. Conditions of coverage. --** As provided in section 27-19-32, coverage shall be extended to new cancer therapies still under investigation when the following circumstances are present:~~

~~(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI), community clinical oncology programs; the Food and Drug Administration in the form of an investigation new drug (IND) exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;~~

~~(2) The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);~~

~~(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;~~

~~(4) The patients receiving the investigational treatment meet all protocol requirements;~~

~~(5) There is no clearly superior, noninvestigational alternative to the protocol treatment;~~

~~(6) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the noninvestigational alternative; and~~

~~(7) The coverage of new cancer therapy treatment provided pursuant to a phase II clinical trial shall not be required for that portion of that treatment that is provided as part of the phase II clinical trial and is funded by a national agency, such as the National Cancer Institute, the Veteran's Administration, the Department of Defense, or funded by commercial organizations such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any portions of a phase II trial which are customarily funded by government, biotechnical and/or pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall~~

continue to be funded in Rhode Island and coverage pursuant to this section shall supplement, not supplant, customary funding.

27-19-32.3. Managed care. -- Nothing in this chapter shall preclude the conducting of managed care reviews and medical necessity reviews by an insurer, hospital or medical service corporation, or health maintenance corporation.

SECTION 16. Sections 27-20-27, 27-20-27.1, 27-20-27.2 and 27-20-27.3 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" are hereby repealed on the effective date of RI General Law 27-20-64.

27-20-27. New cancer therapies -- Under investigation. -- Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state shall provide coverage for new cancer therapies still under investigation as outlined in this chapter.

27-20-27.1. "Reliable evidence" defined. -- "Reliable evidence" means:

(1) Evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature;

(2) A written informed consent used by the treating facility or by another facility studying substantially the same service; or

(3) A written protocol or protocols used by the treating facility or protocols of another facility studying substantially the same service.

27-20-27.2. Conditions of coverage. -- As provided in section 27-20-27, coverage shall be extended to new cancer therapies still under investigation when the following circumstances are present:

(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI), community clinical oncology programs; the Food and Drug Administration in the form of an investigational new drug (IND) exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;

(2) The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);

(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

(4) The patients receiving the investigational treatment meet all protocol requirements;

(5) There is no clearly superior, noninvestigational alternative to the protocol treatment;

1 (6) The available clinical or preclinical data provide a reasonable expectation that the
2 protocol treatment will be at least as efficacious as the noninvestigational alternative; and
3 (7) The coverage of new cancer therapy treatment provided pursuant to a phase II
4 clinical trial is not required for only that portion of that treatment that is provided as part of the
5 phase II clinical trial and is funded by a national agency, such as the National Cancer Institute,
6 the Veteran's Administration, the Department of Defense, or funded by commercial organizations
7 such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any
8 portions of a phase II trial which are customarily funded by government, biotechnical and/or
9 pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall
10 continue to be funded in Rhode Island and coverage pursuant to this section supplements, does
11 not supplant customary funding.
12 **27-20-27.3. Managed care. --** Nothing in this chapter shall preclude the conducting of
13 managed care reviews and medical necessity reviews by an insurer, hospital or medical service
14 corporation, or health maintenance organization. A nonprofit medical service corporation may, as
15 a condition of coverage, require its members to obtain new cancer therapies still under
16 investigation as outlined in this chapter from providers and facilities designated by the nonprofit
17 medical service corporation to render these new cancer therapies.
18 SECTION 17. Sections 27-41-41, 27-41-41.1, 27-41-41.2 and 27-41-41.3 of the General
19 Laws in Chapter 27-41 entitled "Health Maintenance Organizations" are hereby repealed on the
20 effective date of RI General Law 27-41-77.
21 **27-41-41. New cancer therapies -- Under investigation. --** Every individual or group
22 hospital or medical expense insurance policy or individual or group hospital or medical service
23 plan contract delivered, issued for delivery or renewed in this state shall provide coverage for new
24 cancer therapies still under investigation as outlined in this chapter.
25 **27-41-41.1. "Reliable evidence" defined. --** "Reliable evidence" means:
26 (1) Evidence including published reports and articles in authoritative, peer reviewed
27 medical and scientific literature;
28 (2) A written informed consent used by the treating facility or by another facility
29 studying substantially the same service; or
30 (3) A written protocol or protocols used by the treating facility or protocols of another
31 facility studying substantially the same service.
32 **27-41-41.2. Conditions of coverage. --** As provided in section 27-41-41, coverage shall
33 be extended to new cancer therapies still under investigation when the following circumstances
34 are present:

1 (1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has
2 been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer
3 Institute (NCI), community clinical oncology programs; the food and drug administration in the
4 form of an investigational new drug (IND) exemption; the Department of Veterans' Affairs; or a
5 qualified nongovernmental research entity as identified in the guidelines for NCI cancer center
6 support grants;
7 (2) The proposed therapy has been reviewed and approved by a qualified institutional
8 review board (IRB);
9 (3) The facility and personnel providing the treatment are capable of doing so by virtue
10 of their experience, training, and volume of patients treated to maintain expertise;
11 (4) The patients receiving the investigational treatment meet all protocol requirements;
12 (5) There are no clearly superior, noninvestigational alternatives to the protocol
13 treatment;
14 (6) The available clinical or preclinical data provide a reasonable expectation that the
15 protocol treatment will be at least as efficacious as the noninvestigational alternative; and
16 (7) The coverage of new cancer therapy treatment provided pursuant to a phase II
17 clinical trial is not required for only the portion of that treatment that is provided as part of the
18 phase II clinical trial and is funded by a national agency, such as the National Cancer Institute,
19 the Veteran's Administration, the Department of Defense, or funded by commercial organizations
20 such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any
21 portions of a phase II trial which are customarily funded by government, biotechnical and/or
22 pharmaceutical and/or medical device industry sources in Rhode Island or in other states shall
23 continue to be funded in Rhode Island and coverage pursuant to this section supplements, but
24 does not supplant, that customary funding.
25 **27-41-41.3. Managed care. --** Nothing in this chapter shall preclude the conducting of
26 managed care reviews and medical necessity reviews by an insurer, hospital or medical service
27 corporation, or health maintenance organization. A health maintenance organization may as a
28 condition of coverage require its members to obtain these new cancer therapies still under
29 investigation from providers and facilities designated by the health maintenance organization to
30 render these new cancer therapies.
31 SECTION18. This act shall take effect upon passage.

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LC02074/SUB A/4
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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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1 This act would establish health insurance standards consistent with the health insurance
2 standards established in the Patient Protection and Affordable Care Act of 2010, as amended by
3 the Health Care and Education Reconciliation Act of 2010. These rules and standards would
4 include, but are not limited to, prohibitions on rescission of coverage, discrimination in coverage,
5 and prohibitions on annual and lifetime limits of coverage unless such limits meet set minimum
6 amounts, as well as adding definitions to the chapters covering health insurance. Specific
7 provisions of this act shall not be enforced by the commissioner of the RI Office of the Health
8 Insurance Commissioner in the event that corresponding sections of the Patient Protection and
9 Affordable Care Act are repealed or found invalid.
10 This act would take effect upon passage.

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LC02074/SUB A/4
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