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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2012

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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. – It is the purpose of this act to amend Rhode Island general laws
2 so as to be consistent with health insurance market reforms enacted in federal law.
3 SECTION 2. Construction. – This act is intended to establish health insurance standards
4 in addition to, but not inconsistent with the health insurance standards established in the Patient
5 Protection and Affordable Care Act of 2010, as amended by the Health Care and Education
6 Reconciliation Act of 2010.
7 SECTION 3. Chapter 27-18 of the General Laws entitled "Accident and Sickness
8 Insurance Policies" is hereby amended by adding thereto the following section:
9 **27-18-71. Prohibition on preexisting condition exclusions. –** (a) A health insurance
10 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a
11 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:
12 (1) Shall not limit or exclude coverage for an individual under the age of nineteen (19) by
13 imposing a preexisting condition exclusion on that individual.
14 (2) For plan or policy years beginning on or after January 1, 2014, shall not limit or
15 exclude coverage for any individual by imposing a preexisting condition exclusion on that
16 individual.
17 (b) As used in this section:
18 (1) "Preexisting condition exclusion" means a limitation or exclusion of benefits,
19 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.

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 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

1 insurance coverage.

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

4 **27-19-62. Prohibition on preexisting condition exclusions. --** (a) A health insurance
5 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a
6 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

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

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

12 (b) As used in this section:

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

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

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

26 SECTION 6. Chapter 27-20 of the General Laws entitled "Nonprofit Medical Service
27 Corporations" is hereby amended by adding thereto the following section:

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

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.

SECTION 7. Chapter 27-41 of the General Laws entitled "Health Maintenance Organizations" is hereby amended by adding thereto the following section:

27-41-75. 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

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.

SECTION 8. Section 27-18.6-2 and 27-18.6-3 of the General Laws in Chapter 27-18.6 entitled "Large Group Health Insurance Coverage" are hereby amended to read as follows:

27-18.6-2. Definitions. -- The following words and phrases as used in this chapter have the following meanings unless a different meaning is required by the context:

(1) "Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during the period and no premium shall be charged to the participant or beneficiary for any coverage during the period;

(2) "Beneficiary" has the meaning given that term under section 3(8) of the Employee Retirement Security Act of 1974, 29 U.S.C. section 1002(8);

(3) "Bona fide association" means, with respect to health insurance coverage in this state, an association which:

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

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

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

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

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

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

(vii) Has a constitution and bylaws; and

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

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

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

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

(ii) Part 6 of subtitle B of title 1 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1161 et seq., other than section 609 of that act, 29 U.S.C. section 1169; or

(iii) Title XXII of the United States Public Health Service Act, 42 U.S.C. section 300bb-1 et seq.;

(5) "Creditable coverage" has the same meaning as defined in the United States Public Health Service Act, section 2701(c), 42 U.S.C. section 300gg(c), as added by P.L. 104-191;

(6) "Church plan" has the meaning given that term under section 3(33) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(33);

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

(8) "Employee" has the meaning given that term under section 3(6) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(6);

(9) "Employer" has the meaning given that term under section 3(5) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(5), except that the term includes only employers of two (2) or more employees;

(10) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for the enrollment;

(11) "Governmental plan" has the meaning given that term under section 3(32) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(32), and includes any governmental plan established or maintained for its employees by the government of the United States, the government of any state or political subdivision of the state, or by any agency or instrumentality of government;

(12) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with that plan;

(13) "Group health plan" means an employee welfare benefits plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

(14) "Health insurance carrier" or "carrier" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health

1 care services, including, without limitation, an insurance company offering accident and sickness
2 insurance, a health maintenance organization, a nonprofit hospital, medical or dental service
3 corporation, or any other entity providing a plan of health insurance, health benefits, or health
4 services;

5 (15) (i) "Health insurance coverage" means a policy, contract, certificate, or agreement
6 offered by a health insurance carrier to provide, deliver, arrange for, pay for, or reimburse any of
7 the costs of health care services. Health insurance coverage does include short-term and
8 catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as
9 otherwise specifically exempted in this definition;

10 (ii) "Health insurance coverage" does not include one or more, or any combination of,
11 the following "excepted benefits":

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

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

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

17 (D) Workers' compensation or similar insurance;

18 (E) Automobile medical payment insurance;

19 (F) Credit-only insurance;

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

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

24 (iii) "Health insurance coverage" does not include the following "limited, excepted
25 benefits" if they are provided under a separate policy, certificate of insurance, or are not an
26 integral part of the plan:

27 (A) Limited scope dental or vision benefits;

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

30 (C) Any other similar, limited benefits that are specified in federal regulations issued
31 pursuant to P.L. 104-191;

32 (iv) "Health insurance coverage" does not include the following "noncoordinated,
33 excepted benefits" if the benefits are provided under a separate policy, certificate, or contract of
34 insurance, there is no coordination between the provision of the benefits and any exclusion of

1 benefits under any group health plan maintained by the same plan sponsor, and the benefits are
2 paid with respect to an event without regard to whether benefits are provided with respect to the
3 event under any group health plan maintained by the same plan sponsor:
4 (A) Coverage only for a specified disease or illness; and
5 (B) Hospital indemnity or other fixed indemnity insurance;
6 (v) "Health insurance coverage" does not include the following "supplemental, excepted
7 benefits" if offered as a separate policy, certificate, or contract of insurance:
8 (A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the
9 Social Security Act, 42 U.S.C. section 1395ss(g)(1);
10 (B) Coverage supplemental to the coverage provided under 10 U.S.C. section 1071 et
11 seq.; and
12 (C) Similar supplemental coverage provided to coverage under a group health plan;
13 (16) "Health maintenance organization" ("HMO") means a health maintenance
14 organization licensed under chapter 41 of this title;
15 (17) "Health status-related factor" means any of the following factors:
16 (i) Health status;
17 (ii) Medical condition, including both physical and mental illnesses;
18 (iii) Claims experience;
19 (iv) Receipt of health care;
20 (v) Medical history;
21 (vi) Genetic information;
22 (vii) Evidence of insurability, including contributions arising out of acts of domestic
23 violence; and
24 (viii) Disability;
25 (18) "Large employer" means, in connection with a group health plan with respect to a
26 calendar year and a plan year, an employer who employed an average of at least fifty-one (51)
27 employees on business days during the preceding calendar year and who employs at least two (2)
28 employees on the first day of the plan year. In the case of an employer which was not in existence
29 throughout the preceding calendar year, the determination of whether the employer is a large
30 employer shall be based on the average number of employees that is reasonably expected the
31 employer will employ on business days in the current calendar year;
32 (19) "Large group market" means the health insurance market under which individuals
33 obtain health insurance coverage (directly or through any arrangement) on behalf of themselves
34 (and their dependents) through a group health plan maintained by a large employer;

(20) "Late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(i) The first period in which the individual is eligible to enroll under the plan; or

(ii) A special enrollment period;

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

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

(ii) Amounts paid for transportation primarily for and essential to medical care referred to in paragraph (i) of this subdivision; and

(iii) Amounts paid for insurance covering medical care referred to in paragraphs (i) and (ii) of this subdivision;

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

(23) "Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(7);

(24) "Placed for adoption" means, in connection with any placement for adoption of a child with any person, the assumption and retention by that person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation;

(25) "Plan sponsor" has the meaning given that term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(16)(B). "Plan sponsor" also includes any bona fide association, as defined in this section;

(26) "Preexisting condition exclusion" means, with respect to health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the date; and

(27) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary 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. Provided, further, that large group carrier shall not impose a waiting period greater than sixty (60) days.

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

1 coverage subject to 42 U.S.C. section 18011.

2 **27-18.6-3. Limitation on preexisting condition exclusion. --** (a) (1) Notwithstanding
3 any of the provisions of this title to the contrary, a group health plan and a health insurance
4 carrier offering group health insurance coverage, which is not a grandfathered health plan
5 pursuant to 42 U.S.C. section 18011, shall not deny, exclude, or limit benefits with respect to a
6 participant or beneficiary because of a preexisting condition exclusion except if:

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

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

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

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

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

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

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

28 (e) (1) A group health plan or a health insurance carrier offering group health insurance
29 may elect to apply paragraph (a)(1)(iii) of this section based on coverage of benefits within each
30 of several classes or categories of benefits. Those classes or categories of benefits are to be
31 determined by the secretary of the United States Department of Health and Human Services
32 pursuant to regulation. The election shall be made on a uniform basis for all participants and
33 beneficiaries. Under the election, a group health plan or carrier shall count a period of creditable
34 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 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

1 creditable coverage.

2 (h) A group health plan and a health insurance carrier offering group health insurance 3 coverage may not impose any preexisting condition exclusion relating to pregnancy as a 4 preexisting condition <u>or with regard to an individual who is under nineteen (19) years of age</u>.

5 (i) (1) Periods of creditable coverage with respect to an individual shall be established 6 through presentation of certifications. A group health plan and a health insurance carrier offering 7 group health insurance coverage shall provide certifications:

8 (i) At the time an individual ceases to be covered under the plan or becomes covered 9 under a COBRA continuation provision;

10 (ii) In the case of an individual becoming covered under a continuation provision, at the 11 time the individual ceases to be covered under that provision; and

12 (iii) On the request of an individual made not later than twenty-four (24) months after the 13 date of cessation of the coverage described in paragraph (i) or (ii) of this subdivision, whichever 14 is later.

15 (2) The certification under this subsection may be provided, to the extent practicable, at a 16 time consistent with notices required under any applicable COBRA continuation provision.

17 (3) The certification described in this subsection is a written certification of:

18 (i) The period of creditable coverage of the individual under the plan and the coverage (if 19 any) under the COBRA continuation provision; and

20 (ii) The waiting period (if any)(and affiliation period, if applicable) imposed with respect 21 to the individual for any coverage under the plan.

22 (4) To the extent that medical care under a group health plan consists of group health 23 insurance coverage, the plan is deemed to have satisfied the certification requirement under this 24 subsection if the health insurance carrier offering the coverage provides for the certification in 25 accordance with this subsection.

26 (5) In the case of an election taken pursuant to subsection (e) of this section by a group 27 health plan or a health insurance carrier, if the plan or carrier enrolls an individual for coverage 28 under the plan and the individual provides a certification of creditable coverage, upon request of 29 the plan or carrier, the entity which issued the certification shall promptly disclose to the 30 requisition plan or carrier information on coverage of classes and categories of health benefits 31 available under that entity's plan or coverage, and the entity may charge the requesting plan or 32 carrier for the reasonable cost of disclosing the information.

33 (6) Failure of an entity to provide information under this subsection with respect to 34 previous coverage of an individual so as to adversely affect any subsequent coverage of the

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

1 (2) A dependent special enrollment period shall be a period of not less than thirty (30)
2 days and shall begin on the later of:
3 (i) The date dependent coverage is made available; or
4 (ii) The date of the marriage, birth, or adoption or placement for adoption (as the case
5 may be).
6 (3) If an individual seeks to enroll a dependent during the first thirty (30) days of a
7 dependent special enrollment period, the coverage of the dependent shall become effective:
8 (i) In the case of marriage, not later than the first day of the first month beginning after
9 the date the completed request for enrollment is received;
10 (ii) In the case of a dependent's birth, as of the date of the birth; or
11 (iii) In the case of a dependent's adoption or placement for adoption, the date of the
12 adoption or placement for adoption.
13 (l) (1) A health maintenance organization which offers health insurance coverage in
14 connection with a group health plan and which does not impose any preexisting condition
15 exclusion allowed under subsection (a) of this section with respect to any particular coverage
16 option may impose an affiliation period for the coverage option, but only if that period is applied
17 uniformly without regard to any health status-related factors, and the period does not exceed two
18 (2) months (or three (3) months in the case of a late enrollee).
19 (2) For the purposes of this subsection, an affiliation shall begin on the enrollment date.
20 (3) An affiliation period under a plan shall run concurrently with any waiting period
21 under the plan.
22 (4) The director may approve alternative methods from those described under this
23 subsection to address adverse selection.
24 (m) For the purpose of determining creditable coverage pursuant to this chapter, no
25 period before July 1, 1996, shall be taken into account. Individuals who need to establish
26 creditable coverage for periods before July 1, 1996, and who would have the coverage credited
27 but for the prohibition in the preceding sentence may be given credit for creditable coverage for
28 those periods through the presentation of documents or other means in accordance with any rule
29 or regulation that may be established by the secretary of the United States Department of Health
30 and Human Services.
31 (n) In the case of an individual who seeks to establish creditable coverage for any period
32 for which certification is not required because it relates to an event occurring before June 30,
33 1996, the individual may present other credible evidence of coverage in order to establish the
34 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 which is not a grandfathered health plan, as such term is defined in 42 U.S.C. section 18011, shall not deny, exclude, or limit benefits with respect to a participant or beneficiary because of a preexisting condition exclusion.

SECTION 9. Sections 27-50-3, 27-50-4, 27-50-5, 27-50-6 and 27-50-7 of the General Laws in Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" are hereby amended to read as follows:

27-50-3. Definitions. [Effective December 31, 2010.] -- (a) "Actuarial certification" means a written statement signed by a member of the American Academy of Actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 27-50-5, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(b) "Adjusted community rating" means a method used to develop a carrier's premium which spreads financial risk across the carrier's entire small group population in accordance with the requirements in section 27-50-5.

(c) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries controls or is controlled by, or is under common control with, a specified entity or person.

(d) "Affiliation period" means a period of time that must expire before health insurance 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

1 members regardless of any health status-related factor relating to those members (or individuals
2 eligible for coverage through a member);
3 (5) Does not make health insurance coverage offered through the association available
4 other than in connection with a member of the association;
5 (6) Is composed of persons having a common interest or calling;
6 (7) Has a constitution and bylaws; and
7 (8) Meets any additional requirements that the director may prescribe by regulation.
8 (f) "Carrier" or "small employer carrier" means all entities licensed, or required to be
9 licensed, in this state that offer health benefit plans covering eligible employees of one or more
10 small employers pursuant to this chapter. For the purposes of this chapter, carrier includes an
11 insurance company, a nonprofit hospital or medical service corporation, a fraternal benefit
12 society, a health maintenance organization as defined in chapter 41 of this title or as defined in
13 chapter 62 of title 42, or any other entity subject to state insurance regulation that provides
14 medical care as defined in subsection (y) that is paid or financed for a small employer by such
15 entity on the basis of a periodic premium, paid directly or through an association, trust, or other
16 intermediary, and issued, renewed, or delivered within or without Rhode Island to a small
17 employer pursuant to the laws of this or any other jurisdiction, including a certificate issued to an
18 eligible employee which evidences coverage under a policy or contract issued to a trust or
19 association.
20 (g) "Church plan" has the meaning given this term under section 3(33) of the Employee
21 Retirement Income Security Act of 1974 [29 U.S.C. section 1002(33)_.
22 (h) "Control" is defined in the same manner as in chapter 35 of this title.
23 (i) (1) "Creditable coverage" means, with respect to an individual, health benefits or
24 coverage provided under any of the following:
25 (i) A group health plan;
26 (ii) A health benefit plan;
27 (iii) Part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. section 1395c
28 et seq., or 42 U.S.C. section 1395j et seq., (Medicare);
29 (iv) Title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq., (Medicaid),
30 other than coverage consisting solely of benefits under 42 U.S.C. section 1396s (the program for
31 distribution of pediatric vaccines);
32 (v) 10 U.S.C. section 1071 et seq., (medical and dental care for members and certain
33 former members of the uniformed services, and for their dependents)(Civilian Health and
34 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, a child under the age of twenty-six (26) years ~~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 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 anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this eligibility criterion is applied uniformly among all of the employer's employees and without regard to any health status-related factor. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis or who works less than seventeen and one-half (17.5) hours per week. Any retiree under contract with any independently incorporated fire district is also included in the definition of eligible employee, as well as any former employee of an

employer who retired before normal retirement age, as defined by 42 U.S.C. 18002(a)(2)(c) while the employer participates in the early retiree reinsurance program defined by that chapter. Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation requirements pursuant to section 27-50-7(d)(9).

(n) “Eligible individual” means an individual who is not eligible for coverage under a group health plan, part A or part B of title XVIII of the Social Security Act, 42 U.S.C. section 1395c et seq. or 42 U.S.C. section 1395j et seq., or any state plan under title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq. (or any successor program), and does not have other health insurance coverage.

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

~~(o)~~(p) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

~~(p)~~(q) "Family composition" means:

(1) Enrollee;

(2) Enrollee, spouse and children;

(3) Enrollee and spouse; or

(4) Enrollee and children.

~~(q)~~(r) "Genetic information" means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

~~(r)~~(s) "Governmental plan" has the meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(32), and any federal governmental plan.

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

~~(s)~~(u) (1) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the extent that the plan provides medical care, as defined in subsection (y) of this section, and including items and services paid for as medical care to employees or their

dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(2) For purposes of this chapter:

(i) Any plan, fund, or program that would not be, but for PHSA Section 2721(e), 42 U.S.C. section 300gg(e), as added by P.L. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph (ii) of this subdivision, as an employee welfare benefit plan that is a group health plan;

(ii) In the case of a group health plan, the term "employer" also includes the partnership in relation to any partner; and

(iii) In the case of a group health plan, the term "participant" also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary who is, or may become, eligible to receive a benefit under the plan, if:

(A) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership; or

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

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

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

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

(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;

1 (vi) Credit-only insurance;
2 (vii) Coverage for on-site medical clinics; and
3 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant
4 to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other
5 insurance benefits.
6 (3) "Health benefit plan" does not include the following benefits if they are provided
7 under a separate policy, certificate, or contract of insurance or are otherwise not an integral part
8 of the plan:
9 (i) Limited scope dental or vision benefits;
10 (ii) Benefits for long-term care, nursing home care, home health care, community-based
11 care, or any combination of those; or
12 (iii) Other similar, limited benefits specified in federal regulations issued pursuant to
13 Pub. L. No. 104-191.
14 (4) "Health benefit plan" does not include the following benefits if the benefits are
15 provided under a separate policy, certificate or contract of insurance, there is no coordination
16 between the provision of the benefits and any exclusion of benefits under any group health plan
17 maintained by the same plan sponsor, and the benefits are paid with respect to an event without
18 regard to whether benefits are provided with respect to such an event under any group health plan
19 maintained by the same plan sponsor:
20 (i) Coverage only for a specified disease or illness; or
21 (ii) Hospital indemnity or other fixed indemnity insurance.
22 (5) "Health benefit plan" does not include the following if offered as a separate policy,
23 certificate, or contract of insurance:
24 (i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the
25 Social Security Act, 42 U.S.C. section 1395ss(g)(1);
26 (ii) Coverage supplemental to the coverage provided under 10 U.S.C. section 1071 et
27 seq.; or
28 (iii) Similar supplemental coverage provided to coverage under a group health plan.
29 (6) A carrier offering policies or certificates of specified disease, hospital confinement
30 indemnity, or limited benefit health insurance shall comply with the following:
31 (i) The carrier files on or before March 1 of each year a certification with the director
32 that contains the statement and information described in paragraph (ii) of this subdivision;
33 (ii) The certification required in paragraph (i) of this subdivision shall contain the
34 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)~~(w) "Health maintenance organization" or "HMO" means a health maintenance organization licensed under chapter 41 of this title.

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

~~(bb)~~(dd) "Plan sponsor" has the meaning given this term under section 3(16)(B) of the

Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(16)(B).

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

(2) "Preexisting condition" does not mean a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the health benefit plan, provided that the prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.

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

(4) The limitations of coverage permitted by this subsection 27-50-3(ee) shall not apply to health benefit plans regulated under this chapter after January 1, 2014, except that the limitations of coverage permitted by this subsection 27-50-3(ee) shall continue to apply to grandfathered health plans covering eligible individuals, as such term is defined in 42 USC section 18011, after January 1, 2014.

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

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

~~(ff)~~(hh) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~(gg)~~(ii) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to provide health care services to covered individuals.

~~(hh)~~(jj) "Risk adjustment mechanism" means the mechanism established pursuant to section 27-50-16.

(ii) "Self-employed individual" means an individual or sole proprietor who derives a substantial portion of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

~~(jj)~~(kk) "Significant break in coverage" means a period of ninety (90) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

~~(kk)~~(ll) "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)~~(mm) "Waiting period" means, with respect to a group health plan and an individual who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to subsection (j)(2) of this section, a waiting period shall not be considered a gap in coverage. Provided, further, that a waiting period shall not exceed sixty (60) days.

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

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

~~(pp)~~(qq) "Wellness health benefit plan" means the health benefit plan offered by each

small employer carrier pursuant to section 27-50-7.

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

27-50-4. Applicability and scope. -- (a) This chapter applies to any health benefit plan that provides coverage to eligible individuals, and to the employees of a small employer in this state, whether issued directly by a carrier or through a trust, association, or other intermediary, and regardless of issuance or delivery of the policy, if any of the following conditions with respect to small employer coverage are met:

(1) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125, or Section 106 of the United States Internal Revenue Code, 26 U.S.C. section 162, 125, or 106; or

(4) The health benefit plan is marketed to individual employees through an employer.

(b) (1) Except as provided in subdivision (2) of this subsection, for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier.

(2) An affiliated carrier that is a health maintenance organization having a license under chapter 41 of this title or a health maintenance organization as defined in chapter 62 of title 42 may be considered to be a separate carrier for the purposes of this chapter.

(3) Unless otherwise authorized by the director, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if those arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for the health benefit plans being retained by the ceding carrier. The department of business regulation's statutory provisions under this title shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.

(c) The commissioner shall adopt rules to effectuate the orderly merger of the individual health insurance market into the small employer market no earlier than January 1, 2014, and no later than December 31, 2014. Actions pursuant to this subsection shall include the repealing of chapter 27-18.5 relating to individual health insurance coverage pursuant to whatever legislation

1 is necessary.

2 (d) On and after the effective date of the rules relating to the individual health insurance
3 market adopted under subsection (c) of this section, this chapter shall apply to health insurance
4 policies, subscriber contracts, and health benefit plans issued or issued for delivery to a small
5 employer, and to any individual health insurance policy, subscriber contract, or other health
6 benefit plan offered or issued in this state, or issued for delivery in this state, or issued for
7 delivery in another state if the policy, contract or plan certificate covers any individual residing in
8 this state.

9 **27-50-5. Restrictions relating to premium rates. --** (a) Premium rates for health benefit
10 plans subject to this chapter are subject to the following provisions:

11 (1) Subject to subdivision (2) of this subsection, a small employer carrier shall develop
12 its rates based on an adjusted community rate and may only vary the adjusted community rate for:

13 (i) Age except that the community rate shall not vary by more than three (3) to one based
14 on age;

15 (ii) ~~Gender~~ Rating area, except that the state of Rhode Island shall constitute a single
16 area; and

17 (iii) Family composition;

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

21 (3) The small employer carriers are permitted to develop separate rates for individuals
22 age sixty-five (65) or older for coverage for which Medicare is the primary payer and coverage
23 for which Medicare is not the primary payer. Both rates are subject to the requirements of this
24 subsection.

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

28 (5) Premium rates for bona fide associations ~~except for the Rhode Island Builders'~~
29 ~~Association whose membership is limited to those who are actively involved in supporting the~~
30 ~~construction industry in Rhode Island~~ shall comply with the requirements of section 27-50-5.

31 (6) For a small employer group renewing its health insurance with the same small
32 employer carrier which provided it small employer health insurance in the prior year, the
33 ~~combined~~ adjustment factor for age ~~and gender~~ for that small employer group will not exceed one
34 hundred twenty percent (120%) of the ~~combined~~ adjustment factor for age ~~and gender~~ for that

small employer group in the prior rate year.

(b) The premium charged for a health benefit plan may not be adjusted more frequently than annually except that the rates may be changed to reflect:

(1) Changes to the enrollment of the small employer;

(2) Changes to the family composition of the employee; or

(3) Changes to the health benefit plan requested by the small employer.

(c) Premium rates for health benefit plans shall comply with the requirements of this section.

(d) Small employer carriers shall apply rating factors consistently with respect to all small employers and to eligible individuals. Rating factors shall produce premiums for identical groups or individuals that differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans. Two groups that are otherwise identical, but which have different prior year rate factors may, however, have rating factors that produce premiums that differ because of the requirements of subdivision 27-50-5(a)(6). Nothing in this section shall be construed to prevent a group health plan and a health insurance carrier offering health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, including those included in affordable health benefit plans, provided that the resulting rates comply with the other requirements of this section, including subdivision (a)(5) of this section.

The calculation of premium discounts, rebates, or modifications to otherwise applicable copayments or deductibles for affordable health benefit plans shall be made in a manner consistent with accepted actuarial standards and based on actual or reasonably anticipated small employer claims experience. As used in the preceding sentence, "accepted actuarial standards" includes actuarially appropriate use of relevant data from outside the claims experience of small employers covered by affordable health plans, including, but not limited to, experience derived from the large group market, as this term is defined in section 27-18.6-2(19).

(e) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.

(f) The health insurance commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including regulations that assure that differences in

1 rates charged for health benefit plans by small employer carriers are reasonable and reflect
2 objective differences in plan design or coverage (not including differences due to the nature of the
3 groups assumed to select particular health benefit plans or separate claim experience for
4 individual health benefit plans) and to ensure that small employer groups with one eligible
5 subscriber are notified of rates for health benefit plans in the individual market.
6 (g) In connection with the offering for sale of any health benefit plan to a small employer
7 and to eligible individuals, a small employer carrier shall make a reasonable disclosure, as part of
8 its solicitation and sales materials, of all of the following:
9 (1) The provisions of the health benefit plan concerning the small employer carrier's
10 right to change premium rates and the factors, other than claim experience, that affect changes in
11 premium rates;
12 (2) The provisions relating to renewability of policies and contracts;
13 (3) The provisions relating to any preexisting condition provision; and
14 (4) A listing of and descriptive information, including benefits and premiums, about all
15 benefit plans for which the small employer is qualified.
16 (h) (1) Each small employer carrier shall maintain at its principal place of business a
17 complete and detailed description of its rating practices and renewal underwriting practices,
18 including information and documentation that demonstrate that its rating methods and practices
19 are based upon commonly accepted actuarial assumptions and are in accordance with sound
20 actuarial principles.
21 (2) Each small employer carrier shall file with the commissioner annually on or before
22 March 15 an actuarial certification certifying that the carrier is in compliance with this chapter
23 and that the rating methods of the small employer carrier are actuarially sound. The certification
24 shall be in a form and manner, and shall contain the information, specified by the commissioner.
25 A copy of the certification shall be retained by the small employer carrier at its principal place of
26 business.
27 (3) A small employer carrier shall make the information and documentation described in
28 subdivision (1) of this subsection available to the commissioner upon request. Except in cases of
29 violations of this chapter, the information shall be considered proprietary and trade secret
30 information and shall not be subject to disclosure by the director to persons outside of the
31 department except as agreed to by the small employer carrier or as ordered by a court of
32 competent jurisdiction.
33 (4) For the wellness health benefit plan described in section 27-50-10, the rates proposed
34 to be charged and the plan design to be offered by any carrier shall be filed by the carrier at the

office of the commissioner no less than thirty (30) days prior to their proposed date of use. The carrier shall be required to establish that the rates proposed to be charged and the plan design to be offered are consistent with the proper conduct of its business and with the interest of the public. The commissioner may approve, disapprove, or modify the rates and/or approve or disapprove the plan design proposed to be offered by the carrier. Any disapproval by the commissioner of a plan design proposed to be offered shall be based upon a determination that the plan design is not consistent with the criteria established pursuant to subsection 27-50-10(b).

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

27-50-6. Renewability of coverage. -- (a) A health benefit plan subject to this chapter is renewable with respect to all eligible employees or dependents, at the option of the small employer and to all eligible individuals of dependents at the option of the eligible individual unless the~~, except in any of the following cases: (1) The~~ plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the carrier has not received timely premium payments;

(b) With respect to small employer coverage, a health benefit plan subject to this chapter is renewable with respect to all eligible employees or dependents, at the option of the small employer, except in the following cases:

~~(2)~~(1) The plan sponsor or, with respect to coverage of individual insured under the health benefit plan, the insured or the insured's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;

~~(3)~~(2) Noncompliance with the carrier's minimum participation requirements;

~~(4)~~(3) Noncompliance with the carrier's employer contribution requirements;

~~(5)~~(4) The small employer carrier elects to discontinue offering all of its health benefit plans delivered or issued for delivery to small employers in this state if the carrier:

(i) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and

(ii) Provides notice of the decision to:

(A) All affected small employers and enrollees and their dependents; and

(B) The insurance commissioner in each state in which an affected insured individual is known to reside at least one hundred and eighty (180) days prior to the nonrenewal of any health benefit plans by the carrier, provided the notice to the commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected small

employers and enrollees and their dependents;

~~(6)~~(5) The director:

(i) Finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier's ability to meet its contractual obligations; and

(ii) Assists affected small employers in finding replacement coverage;

~~(7)~~(6) The small employer carrier decides to discontinue offering a particular type of health benefit plan in the state's small employer market if the carrier:

(i) Provides notice of the decision not to renew coverage at least ninety (90) days prior to the nonrenewal of any health benefit plans to all affected small employers and enrollees and their dependents;

(ii) Offers to each small employer issued a particular type of health benefit plan the option to purchase all other health benefit plans currently being offered by the carrier to small employers in the state; and

(iii) In exercising this option to discontinue a particular type of health benefit plan and in offering the option of coverage pursuant to paragraph ~~(7)~~(6)(ii) of this subsection acts uniformly without regard to the claims experience of those small employers or any health status-related factor relating to any enrollee or dependent of an enrollee or enrollees and their dependents covered or new enrollees and their dependents who may become eligible for coverage;

~~(8)~~(7) In the case of health benefit plans that are made available in the small group market through a network plan, there is no longer an employee of the small employer living, working or residing within the carrier's established geographic service area and the carrier would deny enrollment in the plan pursuant to section 27-50-7(e)(1)(ii); or

~~(9)~~(8) In the case of a health benefit plan that is made available in the small employer market only through one or more bona fide associations, the membership of an employer in the bona fide association, on the basis of which the coverage is provided, ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

~~(b)~~(c) (1) A small employer carrier that elects not to renew health benefit plan coverage pursuant to subdivision ~~(a)~~(b)(2) of this section because of the small employer's fraud or intentional misrepresentation of material fact under the terms of coverage may choose not to issue a health benefit plan to that small employer for one year after the date of nonrenewal.

(2) This subsection shall not be construed to affect the requirements of section 27-50-7 as to the obligations of other small employer carriers to issue any health benefit plan to the small

employer.

~~(c)~~(d) (1) A small employer carrier that elects to discontinue offering health benefit plans under subdivision ~~(a)~~(b)(5) of this section is prohibited from writing new business in the small employer market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

(2) In the case of a small employer carrier that ceases offering new coverage in this state pursuant to subdivision (a)(5) of this section, the small employer carrier, as determined by the director, may renew its existing business in the small employer market in the state or may be required to nonrenew all of its existing business in the small employer market in the state.

~~(d)~~(e) A small employer carrier offering coverage through a network plan is not required to offer coverage or accept applications pursuant to subsection (a) or (b) or (c) of this section in the case of the following:

(1) To an eligible person who no longer resides, lives, or works in the service area, or in an area for which the carrier is authorized to do business, but only if coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals; or

(2) To a small employer that no longer has any enrollee in connection with the plan who lives, resides, or works in the service area of the carrier, or the area for which the carrier is authorized to do business.

~~(e)~~(f) At the time of coverage renewal, a small employer carrier may modify the health insurance coverage for a product offered to a group health plan if, for coverage that is available in the small group market other than only through one or more bona fide associations, such modification is consistent with otherwise applicable law and effective on a uniform basis among group health plans with that product.

27-50-7. Availability of coverage. -- (a) Until October 1, 2004, for purposes of this section, "small employer" includes any person, firm, corporation, partnership, association, or political subdivision that is actively engaged in business that on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed a combination of no more than fifty (50) and no less than two (2) eligible employees and part-time employees, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. After October 1, 2004, for the purposes of this section, "small employer" has the meaning used in section 27-50-3(kk).

(b) (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to eligible individuals and small employers all health

benefit plans it actively markets to small employers in this state including a wellness health benefit plan. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to any small employer not currently receiving a health benefit plan from the small employer carrier. For the purpose of promoting stability in health insurance coverage for consumers across all markets in this state, and to mitigate against improper incentives for adverse selection between markets, every health insurance company, hospital or medical service corporation, and health maintenance organization which offers coverage through qualified health plans in the Rhode Island health insurance exchange established in accordance with the Affordable Care Act shall actively market and offer the same qualified health plans in the small employer and individual markets.

(2) Subject to subdivision (1) of this subsection, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for that plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter. However, no carrier is required to issue a health benefit plan to any self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

(c) (1) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this subdivision may be used by a small employer carrier beginning thirty (30) days after it is filed unless the director disapproves its use.

(2) The director may at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

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

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

(2) (i) Except as provided in subdivision (3) of this subsection, a small employer carrier shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage without regard to the specific benefits covered during the period of creditable 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~~.~~ ; or

(iii) With regard to an individual who is less than nineteen (19) years of age for policy years. The provisions of this subdivision 27-50-7(d)(5)(iii) shall apply to any health insurance carrier providing coverage under a group health plan, including grandfathered health plans, but the provisions of this subdivision 27-50-7(d)(5)(iii) shall not apply to grandfathered health plans providing individual health insurance coverage..

(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.

(ii) If an employee requests enrollment pursuant to subparagraph (i)(D) of this subdivision, the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

(8) (i) A small employer carrier that makes coverage available under a group health plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in paragraph (ii) of this subdivision during which the person or, if not enrolled, the individual may be enrolled under the group health plan as a dependent of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is eligible for coverage if:

(A) The individual is a participant under the health benefit plan or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan, but for a failure to enroll during a previous enrollment period; and

(B) A person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

(ii) The special enrollment period for individuals that meet the provisions of paragraph (i) of this subdivision is a period of not less than thirty (30) days and begins on the later of:

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

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

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

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

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

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

(9) (i) Except as provided in this subdivision, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements

for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier.

(ii) For health benefit plans issued or renewed on or after October 1, 2000, a small employer carrier shall not require a minimum participation level greater than seventy-five percent (75%) of eligible employees.

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

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

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

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

(iii) ~~Except as permitted under subdivisions (1) and (4) of this subsection, a~~ For a health benefit plan issued after January 1, 2014 a small employer carrier shall not modify a health benefit plan with respect to an eligible individual to his or her dependents or a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services covered by the plan. The provisions of this subdivision shall not apply to any grandfathered plan offered to eligible individuals.

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

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

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

1 (iii) Within an area where the small employer carrier reasonably anticipates, and
2 demonstrates to the satisfaction of the director, that it will not have the capacity within its
3 established geographic service area to deliver services adequately to enrollees of any additional
4 groups because of its obligations to existing group policyholders and enrollees.
5 (2) A small employer carrier that cannot offer coverage pursuant to paragraph (1)(iii) of
6 this subsection may not offer coverage in the applicable area to new cases of employer groups
7 until the later of one hundred and eighty (180) days following each refusal or the date on which
8 the carrier notifies the director that it has regained capacity to deliver services to new employer
9 groups.
10 (3) A small employer carrier shall apply the provisions of this subsection uniformly to all
11 small employers without regard to the claims experience of a small employer and its employees
12 and their dependents or any health status-related factor relating to the employees and their
13 dependents.
14 (f) (1) A small employer carrier is not required to provide coverage to small employers
15 pursuant to subsection (b) of this section if:
16 (i) For any period of time the director determines the small employer carrier does not
17 have the financial reserves necessary to underwrite additional coverage; and
18 (ii) The small employer carrier is applying this subsection uniformly to all small
19 employers in the small group market in this state consistent with applicable state law and without
20 regard to the claims experience of a small employer and its employees and their dependents or
21 any health status-related factor relating to the employees and their dependents.
22 (2) A small employer carrier that denies coverage in accordance with subdivision (1) of
23 this subsection may not offer coverage in the small group market for the later of:
24 (i) A period of one hundred and eighty (180) days after the date the coverage is denied;
25 or
26 (ii) Until the small employer has demonstrated to the director that it has sufficient
27 financial reserves to underwrite additional coverage.
28 (g) (1) A small employer carrier is not required to provide coverage to small employers
29 pursuant to subsection (b) of this section if the small employer carrier elects not to offer new
30 coverage to small employers in this state.
31 (2) A small employer carrier that elects not to offer new coverage to small employers
32 under this subsection may be allowed, as determined by the director, to maintain its existing
33 policies in this state.
34 (3) A small employer carrier that elects not to offer new coverage to small employers

1 under subdivision (g)(1) shall provide at least one hundred and twenty (120) days notice of its
2 election to the director and is prohibited from writing new business in the small employer market
3 in this state for a period of five (5) years beginning on the date the carrier ceased offering new
4 coverage in this state.

5 (g) The provisions of subsections 27-50-7(d)(1), 27-50-7(d)(4), 27-50-7(d)(5) and 27-50-
6 7(d)(6) shall apply to health benefit plans issued before January 1, 2014. With respect to health
7 benefit plans issued on and after January 1, 2014 a small employer carrier shall offer and issue
8 coverage to small employers and eligible individuals notwithstanding any pre-existing condition
9 of an employee, member, of individual, or their dependents. This subsection shall not apply to
10 grandfathered health benefit plans providing coverage to eligible individuals.

11 SECTION 10. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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1 This act would make various amendments to healthcare chapters to ensure consistency
2 with applicable federal law.
3 This act would take effect upon passage.

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