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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2014

A N A C T

RELATING TO INSURANCE -- GENDER RATING

Introduced By: Senators Sosnowski, Miller, Nesselbush, Cool Rumsey, and Gallo

Date Introduced: January 30, 2014

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Chapter 27-18 of the General Laws entitled "Accident and Sickness  
2 Insurance Policies" is hereby amended by adding thereto the following section:

3 27-18-82. Gender rating. – (a) No individual or small group health insurance contract,  
4 plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical  
5 coverage that includes coverage for physician services in a physician's office, and no policy  
6 which provides major medical and/or similar comprehensive-type coverage, excluding policies  
7 listed in (c), shall vary the premium rate for a health coverage plan based on the gender of the  
8 individual policy holders, enrollees, subscribers, or members.

9 (b) Effective April 1, 2016, no large group health insurance employer contract, plan, or  
10 policy delivered, issued for delivery, or renewed in this state, which provides medical coverage  
11 that includes coverage for physician services in a physician's office and any policy which  
12 provides major medical and/or similar comprehensive-type coverage, excluding policies listed in  
13 (c), shall vary the premium rate based on the gender of the individual policy holders, enrollees,  
14 subscribers, or members in any one age group.

15 (c) This section shall not apply to insurance coverage providing benefits for any of the  
16 following:

17 (1) Hospital confinement indemnity;

18 (2) Disability income;

19 (3) Accident only;

- 1           (4) Long-term care;
- 2           (5) Medicare supplement;
- 3           (6) Limited benefit health;
- 4           (7) Specified diseased indemnity;
- 5           (8) Sickness of bodily injury or death by accident or both;
- 6           (9) Other limited benefit policies.

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

9           **27-19-73. Gender rating.** -- (a) No individual or small group health insurance contract,  
10 plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical  
11 coverage that includes coverage for physician services in a physician's office, and no policy  
12 which provides major medical and/or similar comprehensive-type coverage, excluding policies  
13 listed in (c), shall vary the premium rate for a health coverage plan based on the gender of the  
14 individual policy holders, enrollees, subscribers, or members.

15           (b) Effective April 1, 2016, no large group health insurance employer contract, plan, or  
16 policy delivered, issued for delivery, or renewed in this state, which provides medical coverage  
17 that includes coverage for physician services in a physician's office and any policy which  
18 provides major medical and/or similar comprehensive-type coverage, excluding policies listed in  
19 (c), shall vary the premium rate based on the gender of the individual policy holders, enrollees,  
20 subscribers, or members in any one age group.

21           (c) This section shall not apply to insurance coverage providing benefits for any of the  
22 following:

- 23           (1) Hospital confinement indemnity;
- 24           (2) Disability income;
- 25           (3) Accident only;
- 26           (4) Long-term care;
- 27           (5) Medicare supplement;
- 28           (6) Limited benefit health;
- 29           (7) Specified diseased indemnity;
- 30           (8) Sickness of bodily injury or death by accident or both;
- 31           (9) Other limited benefit policies.

32           SECTION 3. Chapter 27-20 of the General Laws entitled "Nonprofit Medical Service  
33           Corporations" is hereby amended by adding thereto the following section:

34           **27-20-69. Gender rating.** -- (a) No individual or small group health insurance contract,

1 plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical  
2 coverage that includes coverage for physician services in a physician's office, and no policy  
3 which provides major medical and/or similar comprehensive-type coverage, excluding policies  
4 listed in (c), shall vary the premium rate for a health coverage plan based on the gender of the  
5 individual policy holders, enrollees, subscribers, or members.

6 (b) Effective April 1, 2016, no large group health insurance employer contract, plan, or  
7 policy delivered, issued for delivery, or renewed in this state, which provides medical coverage  
8 that includes coverage for physician services in a physician's office and any policy which  
9 provides major medical and/or similar comprehensive-type coverage, excluding policies listed in  
10 (c), shall vary the premium rate based on the gender of the individual policy holders, enrollees,  
11 subscribers, or members in any one age group.

12 (c) This section shall not apply to insurance coverage providing benefits for any of the  
13 following:

14 (1) Hospital confinement indemnity;

15 (2) Disability income;

16 (3) Accident only;

17 (4) Long-term care;

18 (5) Medicare supplement;

19 (6) Limited benefit health;

20 (7) Specified diseased indemnity;

21 (8) Sickness of bodily injury or death by accident 1 or both;

22 (9) Other limited benefit policies.

23 SECTION 4. Chapter 27-41 of the General Laws entitled "Health Maintenance  
24 Organizations" is hereby amended by adding thereto the following section:

25 **27-41-86. Gender rating.** -- (a) No individual or small group health insurance contract,  
26 plan, or policy delivered, issued for delivery, or renewed in this state, which provides medical  
27 coverage that includes coverage for physician services in a physician's office, and no policy  
28 which provides major medical and/or similar comprehensive-type coverage, excluding policies  
29 listed in (c), shall vary the premium rate for a health coverage plan based on the gender of the  
30 individual policy holders, enrollees, subscribers, or members.

31 (b) Effective April 1, 2016, no large group health insurance employer contract, plan, or  
32 policy delivered, issued for delivery, or renewed in this state, which provides medical coverage  
33 that includes coverage for physician services in a physician's office and any policy which  
34 provides major medical and/or similar comprehensive-type coverage, excluding policies listed in

1 (c). shall vary the premium rate based on the gender of the individual policy holders, enrollees,  
2 subscribers, or members in any one age group.

3 (c) This section shall not apply to insurance coverage providing benefits for any of the  
4 following:

5 (1) Hospital confinement indemnity;

6 (2) Disability income;

7 (3) Accident only;

8 (4) Long-term care;

9 (5) Medicare supplement;

10 (6) Limited benefit health;

11 (7) Specified diseased indemnity;

12 (8) Sickness of bodily injury or death by accident or both;

13 (9) Other limited benefit policies.

14 SECTION 5. Section 27-50-5 of the General Laws in Chapter 27-50 entitled "Small  
15 Employer Health Insurance Availability Act" is hereby amended to read as follows:

16 **27-50-5. Restrictions relating to premium rates.** -- (a) Premium rates for health plans  
17 subject to this chapter are subject to the following provisions:

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

21 (i) Age; ~~and~~

22 (ii) Gender in accordance with §§ 27-41-86, 27-20-69, 27-19-73, 27-18-82; and

23 (iii) Family composition;

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

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

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

34 (5) Premium rates for bona fide associations except for the Rhode Island Builders'

1 Association whose membership is limited to those who are actively involved in supporting the  
2 construction industry in Rhode Island shall comply with the requirements of section 27-50-5.

3 (6) For a small employer group renewing its health insurance with the same small  
4 employer carrier which provided it small employer health insurance in the prior year, the  
5 combined adjustment factor for age and gender for that small employer group will not exceed one  
6 hundred twenty percent (120%) of the combined adjustment factor for age and gender for that  
7 small employer group in the prior rate year.

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

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

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

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

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

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

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

34 (e) For the purposes of this section, a health benefit plan that contains a restricted

1 network provision shall not be considered similar coverage to a health benefit plan that does not  
2 contain such a provision, provided that the restriction of benefits to network providers results in  
3 substantial differences in claim costs.

4 (f) The health insurance commissioner may establish regulations to implement the  
5 provisions of this section and to assure that rating practices used by small employer carriers are  
6 consistent with the purposes of this chapter, including regulations that assure that differences in  
7 rates charged for health benefit plans by small employer carriers are reasonable and reflect  
8 objective differences in plan design or coverage (not including differences due to the nature of the  
9 groups assumed to select particular health benefit plans or separate claim experience for  
10 individual health benefit plans) and to ensure that small employer groups with one eligible  
11 subscriber are notified of rates for health benefit plans in the individual market.

12 (g) In connection with the offering for sale of any health benefit plan to a small employer,  
13 a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales  
14 materials, of all of the following:

15 (1) The provisions of the health benefit plan concerning the small employer carrier's right  
16 to change premium rates and the factors, other than claim experience, that affect changes  
17 premium rates;

18 (2) The provisions relating to renewability of policies and contracts;

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

20 (4) A listing of and descriptive information, including benefits and premiums, about all  
21 benefit plans for which the small employer is qualified.

22 (h) (1) Each small employer carrier shall maintain at its principal place of business a  
23 complete and detailed description of its rating practices and renewal underwriting practices,  
24 including information and documentation that demonstrate that its rating methods and practices  
25 are based upon commonly accepted actuarial assumptions and are in accordance with sound  
26 actuarial principles.

27 (2) Each small employer carrier shall file with the commissioner annually on or before  
28 March 15 an actuarial certification certifying that the carrier is in compliance with this chapter  
29 and that the rating methods of the small employer carrier are actuarially sound. The certification  
30 shall be in a form and manner, and shall contain the information, specified by the commissioner.  
31 A copy of the certification shall be retained by the small employer carrier at its principal place of  
32 business.

33 (3) A small employer carrier shall make the information and documentation described in  
34 subdivision (1) of this subsection available to the commissioner upon request. Except in cases of

1 violations of this chapter, the information shall be considered proprietary and trade secret  
2 information and shall not be subject to disclosure by the director to persons outside of the  
3 department except as agreed to by the small employer carrier or as ordered by a court of  
4 competent jurisdiction.

5 (4) For the wellness health benefit plan described in section 27-50-10, the rates proposed  
6 to be charged and the plan design to be offered by any carrier shall be filed by the carrier at the  
7 office of the commissioner no less than thirty (30) days prior to their proposed date of use. The  
8 carrier shall be required to establish that the rates proposed to be charged and the plan design to  
9 be offered are consistent with the proper conduct of its business and with the interest of the  
10 public. The commissioner may approve, disapprove, or modify the rates and/or approve or  
11 disapprove the plan design proposed to be offered by the carrier. Any disapproval by the  
12 commissioner of a plan design proposed to be offered shall be based upon a determination that  
13 the plan design is not consistent with the criteria established pursuant to subsection 27-50- (b).

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

16 SECTION 6. Section 27-18-71 of the General Laws in Chapter 27-18 entitled "Accident  
17 and Sickness Insurance Policies" is hereby amended to read as follows:

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

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

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

26 (b) As used in this section:

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

32 ~~(2) "Preexisting condition exclusion" means any limitation or exclusion of benefits,~~  
33 ~~including a denial of coverage, applicable to an individual as a result of information relating to an~~  
34 ~~individual's health status before the individual's effective date of coverage, or if the coverage is~~

1 ~~denied, the date of denial, under the health benefit plan, such as a condition (whether physical or~~  
2 ~~mental) identified as a result of a pre-enrollment questionnaire or physical examination given to~~  
3 ~~the individual, or review of medical records relating to the pre-enrollment period.~~

4 "Preexisting condition exclusion" means: with respect to coverage, a limitation or  
5 exclusion of benefits relating to a condition based on the fact that the condition was present  
6 before the date of enrollment for such coverage, whether or not any medical advice, diagnosis,  
7 care, or treatment was recommended or received before such date.

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

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

14 SECTION 7. Section 27-18.5-10 of the General Laws in Chapter 27-18.5 entitled  
15 "Individual Health Insurance Coverage" is hereby amended to read as follows:

16 **27-18.5-10. Prohibition on preexisting condition exclusions.** -- (a) A health insurance  
17 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a  
18 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

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

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

24 (b) As used in this section:

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

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



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

2 "Preexisting condition exclusion" means: with respect to coverage, a limitation or  
3 exclusion of benefits relating to a condition based on the fact that the condition was present  
4 before the date of enrollment for such coverage, whether or not any medical advice, diagnosis,  
5 care, or treatment was recommended or received before such date.

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

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

12 SECTION 8. Section 27-19-68 of the General Laws in Chapter 27-19 entitled "Nonprofit  
13 Hospital Service Corporations" is hereby amended to read as follows:

14 **27-19-68. Prohibition preexisting condition exclusions.** -- (a) A health insurance  
15 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a  
16 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

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

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

22 (b) As used in this section:

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

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

34 "Preexisting condition exclusion" means: with respect to coverage, a limitation or

1 exclusion of benefits relating to a condition based on the fact that the condition was present  
2 before the date of enrollment for such coverage, whether or not any medical advice, diagnosis,  
3 care, or treatment was recommended or received before such date.

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

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

10 SECTION 9. Section 27-20-57 of the General Laws in Chapter 27-20 entitled "Nonprofit  
11 Medical Service Corporations" is hereby amended to read as follows:

12 **27-20-57. Prohibition preexisting condition exclusions.** -- (a) A health insurance

13 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a  
14 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

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

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

20 (b) As used in this section:

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

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

32 "Preexisting condition exclusion" means: with respect to coverage, a limitation or  
33 exclusion of benefits relating to a condition based on the fact that the condition was present  
34 before the date of enrollment for such coverage, whether or not any medical advice, diagnosis,

1 [care, or treatment was recommended or received before such date.](#)

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

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

8 SECTION 10. Section 27-41-81 of the General Laws in Chapter 27-41 entitled "Health  
9 Maintenance Organizations" is hereby amended to read as follows:

10 **27-41-81. Prohibition preexisting condition exclusions.** -- (a) A health insurance  
11 policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a  
12 resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

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

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

18 (b) As used in this section:

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

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

30 ["Preexisting condition exclusion" means: with respect to coverage, a limitation or](#)  
31 [exclusion of benefits relating to a condition based on the fact that the condition was present](#)  
32 [before the date of enrollment for such coverage, whether or not any medical advice, diagnosis,](#)  
33 [care, or treatment was recommended or received before such date.](#)

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

1 insurance coverage.

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

6 SECTION 11. Sections 27-50-3 and 27-50-7 of the General Laws in Chapter 27-50  
7 entitled "Small Employer Health Insurance Availability Act" are hereby amended to read as  
8 follows:

9 **27-50-3. Definitions. [Effective December 31, 2010].** -- (a) "Actuarial certification"  
10 means a written statement signed by a member of the American Academy of Actuaries or other  
11 individual acceptable to the director that a small employer carrier is in compliance with the  
12 provisions of section 27-50-5, based upon the person's examination and including a review of the  
13 appropriate records and the actuarial assumptions and methods used by the small employer carrier  
14 in establishing premium rates for applicable health benefit plans.

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

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

21 (d) "Affiliation period" means a period of time that must expire before health insurance  
22 coverage provided by a carrier becomes effective, and during which the carrier is not required to  
23 provide benefits.

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

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

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

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

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

34 (5) Does not make health insurance coverage offered through the association available

1 other than in connection with a member of the association;

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

3 (7) Has a constitution and bylaws; and

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

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

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

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

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

22 (i) A group health plan;

23 (ii) A health benefit plan;

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

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

29 (v) 10 U.S.C. section 1071 et seq., (medical and dental care for members and certain  
30 former members of the uniformed services, and for their dependents)(Civilian Health and  
31 Medical Program of the Uniformed Services)(CHAMPUS). For purposes of 10 U.S.C. section  
32 1071 et seq., "uniformed services" means the armed forces and the commissioned corps of the  
33 National Oceanic and Atmospheric Administration and of the Public Health Service;

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

- 1 (vii) A state health benefits risk pool;
- 2 (viii) A health plan offered under 5 U.S.C. section 8901 et seq., (Federal Employees  
3 Health Benefits Program (FEHBP));
- 4 (ix) A public health plan, which for purposes of this chapter, means a plan established or  
5 maintained by a state, county, or other political subdivision of a state that provides health  
6 insurance coverage to individuals enrolled in the plan; or
- 7 (x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. section  
8 2504(e)).
- 9 (2) A period of creditable coverage shall not be counted, with respect to enrollment of an  
10 individual under a group health plan, if, after the period and before the enrollment date, the  
11 individual experiences a significant break in coverage.
- 12 (j) "Dependent" means a spouse, child under the age twenty-six (26) years, and an  
13 unmarried child of any age who is financially dependent upon, the parent and is medically  
14 determined to have a physical or mental impairment which can be expected to result in death or  
15 which has lasted or can be expected to last for a continuous period of not less than twelve (12)  
16 months.
- 17 (k) "Director" means the director of the department of business regulation.
- 18 (l) [Deleted by P.L. 2006, ch. 258, section 2, and P.L. 2006, ch. 296, section 2.]
- 19 (m) "Eligible employee" means an employee who works on a full-time basis with a  
20 normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the  
21 term shall also include an employee who works on a full-time basis with a normal work week of  
22 anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this  
23 eligibility criterion is applied uniformly among all of the employer's employees and without  
24 regard to any health status-related factor. The term includes a self-employed individual, a sole  
25 proprietor, a partner of a partnership, and may include an independent contractor, if the self-  
26 employed individual, sole proprietor, partner, or independent contractor is included as an  
27 employee under a health benefit plan of a small employer, but does not include an employee who  
28 works on a temporary or substitute basis or who works less than seventeen and one-half (17.5)  
29 hours per week. Any retiree under contract with any independently incorporated fire district is  
30 also included in the definition of eligible employee, as well as any former employee of an  
31 employer who retired before normal retirement age, as defined by 42 U.S.C. 18002(a)(2)(c) while  
32 the employer participates in the early retiree reinsurance program defined by that chapter. Persons  
33 covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation  
34 Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation

1 requirements pursuant to section 27-50-7(d)(9).

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

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

7 (p) "Family composition" means:

8 (1) Enrollee;

9 (2) Enrollee, spouse and children;

10 (3) Enrollee and spouse; or

11 (4) Enrollee and children.

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

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

20 (s) (1) "Group health plan" means an employee welfare benefit plan as defined in section  
21 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the  
22 extent that the plan provides medical care, as defined in subsection (y) of this section, and  
23 including items and services paid for as medical care to employees or their dependents as defined  
24 under the terms of the plan directly or through insurance, reimbursement, or otherwise.

25 (2) For purposes of this chapter:

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

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

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

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

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

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

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

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

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

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

21 (iv) Workers' compensation or similar insurance;

22 (v) Automobile medical payment insurance;

23 (vi) Credit-only insurance;

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

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

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

31 (i) Limited scope dental or vision benefits;

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

34 (iii) Other similar, limited benefits specified in federal regulations issued pursuant to



1 Pub. L. No. 104-191.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 (v) "Health status-related factor" means any of the following factors:
- 2 (1) Health status;
- 3 (2) Medical condition, including both physical and mental illnesses;
- 4 (3) Claims experience;
- 5 (4) Receipt of health care;
- 6 (5) Medical history;
- 7 (6) Genetic information;
- 8 (7) Evidence of insurability, including conditions arising out of acts of domestic  
9 violence; or
- 10 (8) Disability.
- 11 (w) (1) "Late enrollee" means an eligible employee or dependent who requests  
12 enrollment in a health benefit plan of a small employer following the initial enrollment period  
13 during which the individual is entitled to enroll under the terms of the health benefit plan,  
14 provided that the initial enrollment period is a period of at least thirty (30) days.
- 15 (2) "Late enrollee" does not mean an eligible employee or dependent:
- 16 (i) Who meets each of the following provisions:
- 17 (A) The individual was covered under creditable coverage at the time of the initial  
18 enrollment;
- 19 (B) The individual lost creditable coverage as a result of cessation of employer  
20 contribution, termination of employment or eligibility, reduction in the number of hours of  
21 employment, involuntary termination of creditable coverage, or death of a spouse, divorce or  
22 legal separation, or the individual and/or dependents are determined to be eligible for RItCare  
23 under chapter 5.1 of title 40 or chapter 12.3 of title 42 or for RItShare under chapter 8.4 of title  
24 40; and
- 25 (C) The individual requests enrollment within thirty (30) days after termination of the  
26 creditable coverage or the change in conditions that gave rise to the termination of coverage;
- 27 (ii) If, where provided for in contract or where otherwise provided in state law, the  
28 individual enrolls during the specified bona fide open enrollment period;
- 29 (iii) If the individual is employed by an employer which offers multiple health benefit  
30 plans and the individual elects a different plan during an open enrollment period;
- 31 (iv) If a court has ordered coverage be provided for a spouse or minor or dependent child  
32 under a covered employee's health benefit plan and a request for enrollment is made within thirty  
33 (30) days after issuance of the court order;
- 34 (v) If the individual changes status from not being an eligible employee to becoming an

1 eligible employee and requests enrollment within thirty (30) days after the change in status;

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

4 (vii) Who meets the requirements for special enrollment pursuant to section 27-50-7 or  
5 27-50-8.

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

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

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

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

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

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

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

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

24 (cc) (1) "Preexisting condition" means ~~a condition, regardless of the cause of the~~  
25 ~~condition, for which medical advice, diagnosis, care, or treatment was recommended or received~~  
26 ~~during the six (6) months immediately preceding the enrollment date of the coverage.:~~ with  
27 respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact  
28 the condition was present before the date of enrollment for such coverage, whether or not any  
29 medical advice, diagnosis, care, or treatment was recommended or received before such date.

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

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

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

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

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

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

14 (hh) "Risk adjustment mechanism" means the mechanism established pursuant to section  
15 27-50-16.

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

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

24 (kk) "Small employer" means, except for its use in section 27-50-7, any person, firm,  
25 corporation, partnership, association, political subdivision, or self-employed individual that is  
26 actively engaged in business including, but not limited to, a business or a corporation organized  
27 under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of  
28 another state that, on at least fifty percent (50%) of its working days during the preceding  
29 calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week  
30 of thirty (30) or more hours, the majority of whom were employed within this state, and is not  
31 formed primarily for purposes of buying health insurance and in which a bona fide employer-  
32 employee relationship exists. In determining the number of eligible employees, companies that  
33 are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation  
34 by this state, shall be considered one employer. Subsequent to the issuance of a health benefit

1 plan to a small employer and for the purpose of determining continued eligibility, the size of a  
2 small employer shall be determined annually. Except as otherwise specifically provided,  
3 provisions of this chapter that apply to a small employer shall continue to apply at least until the  
4 plan anniversary following the date the small employer no longer meets the requirements of this  
5 definition. The term small employer includes a self-employed individual.

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

11 (mm) "Wellness health benefit plan" means a plan developed pursuant to section 27-50-  
12 10.

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

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

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

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

21 **27-50-7. Availability of coverage.** -- (a) Until October 1, 2004, for purposes of this  
22 section, "small employer" includes any person, firm, corporation, partnership, association, or  
23 political subdivision that is actively engaged in business that on at least fifty percent (50%) of its  
24 working days during the preceding calendar quarter, employed a combination of no more than  
25 fifty (50) and no less than two (2) eligible employees and part-time employees, the majority of  
26 whom were employed within this state, and is not formed primarily for purposes of buying health  
27 insurance and in which a bona fide employer-employee relationship exists. After October 1, 2004,  
28 for the purposes of this section, "small employer" has the meaning used in section 27-50-3(kk).

29 (b) (1) Every small employer carrier shall, as a condition of transacting business in this  
30 state with small employers, actively offer to small employers all health benefit plans it actively  
31 markets to small employers in this state including a wellness health benefit plan. A small  
32 employer carrier shall be considered to be actively marketing a health benefit plan if it offers that  
33 plan to any small employer not currently receiving a health benefit plan from the small employer  
34 carrier.

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

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

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

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

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

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

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

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

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

34           (B) During which the carrier charges no premiums and the coverage issued is not

1 effective; and

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

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

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

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

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

12 (B) Count a period of creditable coverage with respect to any class or category of  
13 benefits if any level of benefits is covered within the class or category.

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

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

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

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

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

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

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

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

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

1 enrollment date of the new coverage.

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

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

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

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

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

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

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

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

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

34 (A) The individual is a participant under the health benefit plan or has met any waiting



1 period applicable to becoming a participant under the plan and is eligible to be enrolled under the  
2 plan, but for a failure to enroll during a previous enrollment period; and

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

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

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

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

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

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

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

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

18 (9) (i) Except as provided in this subdivision, requirements used by a small employer  
19 carrier in determining whether to provide coverage to a small employer, including requirements  
20 for minimum participation of eligible employees and minimum employer contributions, shall be  
21 applied uniformly among all small employers applying for coverage or receiving coverage from  
22 the small employer carrier.

23 (ii) For health benefit plans issued or renewed on or after October 1, 2000, a small  
24 employer carrier shall not require a minimum participation level greater than seventy-five percent  
25 (75%) of eligible employees.

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

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

32 (10) (i) If a small employer carrier offers coverage to a small employer, the small  
33 employer carrier shall offer coverage to all of the eligible employees of a small employer and  
34 their dependents who apply for enrollment during the period in which the employee first becomes

1 eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to  
2 only certain individuals or dependents in a small employer group or to only part of the group.

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

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

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

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

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

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

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

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

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

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

34 (ii) The small employer carrier is applying this subsection uniformly to all small

1 employers in the small group market in this state consistent with applicable state law and without  
2 regard to the claims experience of a small employer and its employees and their dependents or  
3 any health status-related factor relating to the employees and their dependents.

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

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

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

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

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

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

21 (h) No small group carrier may impose a pre-existing condition exclusion pursuant to the  
22 provisions of subdivisions 27-50-7(d)(1), 27-50-7(d)(2), 27-50-7(d)(3), 27-50-7(d)(4), 27-50-  
23 7(d)(5) and 27-50-7(d)(6) with regard to an individual that is less than nineteen (19) years of age.

24 Notwithstanding any provision of this section or of any general or public law to the contrary,

25 ~~With~~ with respect to health benefit plans issued on and after January 1, 2014 a small employer  
26 carrier shall offer and issue coverage to small employers and eligible individuals notwithstanding  
27 any pre-existing condition of an employee, member, or individual, or their dependents.

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

30 **27-18.6-3. Limitation on preexisting condition exclusion.** -- (a) (1) Notwithstanding  
31 any of the provisions of this title to the contrary, a group health plan and a health insurance  
32 carrier offering group health insurance coverage shall not deny, exclude, or limit benefits with  
33 respect to a participant or beneficiary because of a preexisting condition exclusion except if:

34 (i) The exclusion relates to a condition (whether physical or mental), regardless of the

1 cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended  
2 or received within the six (6) month period ending on the enrollment date;

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

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

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

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

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

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

21 (e) (1) A group health plan or a health insurance carrier offering group health insurance  
22 may elect to apply paragraph (a)(1)(iii) of this section based on coverage of benefits within each  
23 of several classes or categories of benefits. Those classes or categories of benefits are to be  
24 determined by the secretary of the United States Department of Health and Human Services  
25 pursuant to regulation. The election shall be made on a uniform basis for all participants and  
26 beneficiaries. Under the election, a group health plan or carrier shall count a period of creditable  
27 coverage with respect to any class or category of benefits if any level of benefits is covered  
28 within the class or category.

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

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

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

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

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

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

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

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

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

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

29           (h) A group health plan and a health insurance carrier offering group health insurance  
30 coverage may not impose any preexisting condition exclusion relating to pregnancy as a  
31 preexisting condition or with regard to an individual who is under nineteen (19) years of age.

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

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

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

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

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

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

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

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

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

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

26 (6) Failure of an entity to provide information under this subsection with respect to  
27 previous coverage of an individual so as to adversely affect any subsequent coverage of the  
28 individual under another group health plan or health insurance coverage, as determined in  
29 accordance with rules and regulations established by the secretary of the United States  
30 Department of Health and Human Services, is a violation of this chapter.

31 (j) A group health plan and a health insurance carrier offering group health insurance  
32 coverage in connection with a group health plan shall permit an employee who is eligible, but not  
33 enrolled, for coverage under the terms of the plan (or a dependent of an employee if the  
34 dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under

1 the terms of the plan if each of the following conditions are met:

2 (1) The employee or dependent was covered under a group health plan or had health  
3 insurance coverage at the time coverage was previously offered to the employee or dependent;

4 (2) The employee stated in writing at the time that coverage under a group health plan or  
5 health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or  
6 carrier (if applicable) required a statement at the time and provided the employee with notice of  
7 that requirement (and the consequences of the requirement) at the time;

8 (3) The employee's or dependent's coverage described in subsection (j)(1):

9 (i) Was under a COBRA continuation provision and the coverage under that provision  
10 was exhausted; or

11 (ii) Was not under a continuation provision and either the coverage was terminated as a  
12 result of loss of eligibility for the coverage (including as a result of legal separation, divorce,  
13 death, termination of employment, or reduction in the number of hours of employment) or  
14 employer contributions towards the coverage were terminated; and

15 (4) Under the terms of the plan, the employee requests enrollment not later than thirty  
16 (30) days after the date of exhaustion of coverage described in paragraph (3)(i) of this subsection  
17 or termination of coverage or employer contribution described in paragraph (3)(ii) of this  
18 subsection.

19 (k) (1) If a group health plan makes coverage available with respect to a dependent of an  
20 individual, the individual is a participant under the plan (or has met any waiting period applicable  
21 to becoming a participant under the plan and is eligible to be enrolled under the plan but for a  
22 failure to enroll during a previous enrollment period), and a person becomes a dependent of the  
23 individual through marriage, birth, or adoption or placement through adoption, the group health  
24 plan shall provide for a dependent special enrollment period during which the person (or, if not  
25 enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in  
26 the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a  
27 dependent of the individual if the spouse is eligible for coverage.

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

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

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

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

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

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

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

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

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

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

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

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

24 (n) In the case of an individual who seeks to establish creditable coverage for any period  
25 for which certification is not required because it relates to an event occurring before June 30,  
26 1996, the individual may present other credible evidence of coverage in order to establish the  
27 period of creditable coverage. The group health plan and a health insurance carrier shall not be  
28 subject to any penalty or enforcement action with respect to the plan's or carrier's crediting (or not  
29 crediting) the coverage if the plan or carrier has sought to comply in good faith with the  
30 applicable requirements of this section.

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



1 exclusion.

2 SECTION 13. This act shall take effect upon passage.

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LC003873/SUB A  
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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF  
A N A C T  
RELATING TO INSURANCE -- GENDER RATING

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1           This act would provide that insurance companies shall not vary the premium rates  
2 charged for a health coverage plan based on the gender of the individual policy holder, enrollee,  
3 subscriber, or member.

4           This act would take effect upon passage.

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LC003873/SUB A  
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