

2007 -- H 5301

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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2007

A N A C T

RELATING TO INSURANCE

Introduced By: Representatives Ginaitt, and Lewiss

Date Introduced: February 06, 2007

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Sections 27-50-3 and 27-50-4 of the General Laws in Chapter 27-50
2 entitled "Small Employer Health Insurance Availability Act" are hereby amended to read as
3 follows:

4 **27-50-3. Definitions. [Effective January 1, 2007; effective until July 1, 2007.] --** (a)
5 "Actuarial certification" means a written statement signed by a member of the American
6 Academy of Actuaries or other individual acceptable to the director that a small employer carrier
7 is in compliance with the provisions of section 27-50-5, based upon the person's examination and
8 including a review of the appropriate records and the actuarial assumptions and methods used by
9 the small employer carrier in establishing premium rates for applicable health benefit plans.

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

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

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

19 (e) "Bona fide association" means, with respect to health benefit plans offered in this

1 state, an association which:

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

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

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

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

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

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

13 (7) Has a constitution and bylaws; and

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

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

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

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

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

32 (i) A group health plan;

33 (ii) A health benefit plan;

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

1 et seq., or 42 U.S.C. section 1395j et seq., (Medicare);

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

5 (v) 10 U.S.C. section 1071 et seq., (medical and dental care for members and certain
6 former members of the uniformed services, and for their dependents)(Civilian Health and
7 Medical Program of the Uniformed Services)(CHAMPUS). For purposes of 10 U.S.C. section
8 1071 et seq., "uniformed services" means the armed forces and the commissioned corps of the
9 national oceanic and atmospheric administration and of the public health service;

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

11 (vii) A state health benefits risk pool;

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

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

17 (x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. section
18 2504(e)).

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

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

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

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

29 (m) "Eligible employee" means an employee who works on a full-time basis with a
30 normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the
31 term shall also include an employee who works on a full-time basis with a normal work week of
32 anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this
33 eligibility criterion is applied uniformly among all of the employer's employees and without
34 regard to any health status-related factor. The term includes a self-employed individual, a sole

1 proprietor, a partner of a partnership, and may include an independent contractor, if the self-
2 employed individual, sole proprietor, partner, or independent contractor is included as an
3 employee under a health benefit plan of a small employer, but does not include an employee who
4 works on a temporary or substitute basis or who works less than seventeen and one-half (17.5)
5 hours per week. Any retiree under contract with any independently incorporated fire district is
6 also included in the definition of eligible employee. Persons covered under a health benefit plan
7 pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered
8 "eligible employees" for purposes of minimum participation requirements pursuant to section 27-
9 50-7(d)(9).

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

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

15 (p) "Family composition" means:

- 16 (1) Enrollee;
- 17 (2) Enrollee, spouse and children;
- 18 (3) Enrollee and spouse; or
- 19 (4) Enrollee and children.

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

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

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

33 (2) For purposes of this chapter:

34 (i) Any plan, fund, or program that would not be, but for PHSA Section 2721(e), 42

1 U.S.C. section 300gg(e), as added by P.L. 104-191, an employee welfare benefit plan and that is
2 established or maintained by a partnership, to the extent that the plan, fund or program provides
3 medical care, including items and services paid for as medical care, to present or former partners
4 in the partnership, or to their dependents, as defined under the terms of the plan, fund or program,
5 directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph
6 (ii) of this subdivision, as an employee welfare benefit plan that is a group health plan;

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

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

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

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

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

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

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

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

27 (iii) Liability insurance, including general liability insurance and automobile liability
28 insurance;

29 (iv) Workers' compensation or similar insurance;

30 (v) Automobile medical payment insurance;

31 (vi) Credit-only insurance;

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

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

1 insurance benefits.

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

5 (i) Limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (B) A summary description of each policy or certificate described in this paragraph,

1 including the average annual premium rates (or range of premium rates in cases where premiums
2 vary by age or other factors) charged for those policies and certificates in this state; and

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

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

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

- 10 (1) Health status;
- 11 (2) Medical condition, including both physical and mental illnesses;
- 12 (3) Claims experience;
- 13 (4) Receipt of health care;
- 14 (5) Medical history;
- 15 (6) Genetic information;
- 16 (7) Evidence of insurability, including conditions arising out of acts of domestic
17 violence; or
- 18 (8) Disability.

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

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

24 (i) Who meets each of the following provisions:

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

27 (B) The individual lost creditable coverage as a result of cessation of employer
28 contribution, termination of employment or eligibility, reduction in the number of hours of
29 employment, involuntary termination of creditable coverage, or death of a spouse, divorce or
30 legal separation, or the individual and/or dependents are determined to be eligible for RItCare
31 under chapter 5.1 of title 40 or chapter 12.3 of title 42 or for RItShare under chapter 8.4 of title
32 40; and

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

- 1 (ii) If, where provided for in contract or where otherwise provided in state law, the
2 individual enrolls during the specified bona fide open enrollment period;
- 3 (iii) If the individual is employed by an employer which offers multiple health benefit
4 plans and the individual elects a different plan during an open enrollment period;
- 5 (iv) If a court has ordered coverage be provided for a spouse or minor or dependent child
6 under a covered employee's health benefit plan and a request for enrollment is made within thirty
7 (30) days after issuance of the court order;
- 8 (v) If the individual changes status from not being an eligible employee to becoming an
9 eligible employee and requests enrollment within thirty (30) days after the change in status;
- 10 (vi) If the individual had coverage under a COBRA continuation provision and the
11 coverage under that provision has been exhausted; or
- 12 (vii) Who meets the requirements for special enrollment pursuant to section 27-50-7 or
13 27-50-8.
- 14 (x) "Limited benefit health insurance" means that form of coverage that pays stated
15 predetermined amounts for specific services or treatments or pays a stated predetermined amount
16 per day or confinement for one or more named conditions, named diseases or accidental injury.
- 17 (y) "Medical care" means amounts paid for:
- 18 (1) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid
19 for the purpose of affecting any structure or function of the body;
- 20 (2) Transportation primarily for and essential to medical care referred to in subdivision
21 (1); and
- 22 (3) Insurance covering medical care referred to in subdivisions (1) and (2) of this
23 subsection.
- 24 (z) "Network plan" means a health benefit plan issued by a carrier under which the
25 financing and delivery of medical care, including items and services paid for as medical care, are
26 provided, in whole or in part, through a defined set of providers under contract with the carrier.
- 27 (aa) "Person" means an individual, a corporation, a partnership, an association, a joint
28 venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any
29 combination of the foregoing.
- 30 (bb) "Plan sponsor" has the meaning given this term under section 3(16)(B) of the
31 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(16)(B).
- 32 (cc) (1) "Preexisting condition" means a condition, regardless of the cause of the
33 condition, for which medical advice, diagnosis, care, or treatment was recommended or received
34 during the six (6) months immediately preceding the enrollment date of the coverage.

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

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

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

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

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

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

19 (hh) "Risk adjustment mechanism" means the mechanism established pursuant to section
20 27-50-16.

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

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

29 (kk) "Small employer" means, except for its use in section 27-50-7, any person, firm,
30 corporation, partnership, association, political subdivision, or self-employed individual that is
31 actively engaged in business including, but not limited to, a business or a corporation organized
32 under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of
33 another state that, on at least fifty percent (50%) of its working days during the preceding
34 calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week

1 of thirty (30) or more hours, the majority of whom were employed within this state, and is not
2 formed primarily for purposes of buying health insurance and in which a bona fide employer-
3 employee relationship exists. In determining the number of eligible employees, companies that
4 are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation
5 by this state, shall be considered one employer. Subsequent to the issuance of a health benefit
6 plan to a small employer and for the purpose of determining continued eligibility, the size of a
7 small employer shall be determined annually. Except as otherwise specifically provided,
8 provisions of this chapter that apply to a small employer shall continue to apply at least until the
9 plan anniversary following the date the small employer no longer meets the requirements of this
10 definition. The term small employer includes a self-employed individual.

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

16 (mm) "Wellness health benefit plan" means a plan developed pursuant to section 27-50-
17 10.

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

21 **27-50-3. Definitions. [Effective July 1, 2007.]** -- (a) "Actuarial certification" means a
22 written statement signed by a member of the American Academy of Actuaries or other individual
23 acceptable to the director that a small employer carrier is in compliance with the provisions of
24 section 27-50-5, based upon the person's examination and including a review of the appropriate
25 records and the actuarial assumptions and methods used by the small employer carrier in
26 establishing premium rates for applicable health benefit plans.

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

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

33 (d) "Affiliation period" means a period of time that must expire before health insurance
34 coverage provided by a carrier becomes effective, and during which the carrier is not required to

1 provide benefits.

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

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

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

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

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

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

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

15 (7) Has a constitution and bylaws; and

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

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

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

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

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

34 (i) A group health plan;

- 1 (ii) A health benefit plan;
- 2 (iii) Part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. section 1395c
3 et seq., or 42 U.S.C. section 1395j et seq., (Medicare);
- 4 (iv) Title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq., (Medicaid),
5 other than coverage consisting solely of benefits under 42 U.S.C. section 1396s (the program for
6 distribution of pediatric vaccines);
- 7 (v) 10 U.S.C. section 1071 et seq., (medical and dental care for members and certain
8 former members of the uniformed services, and for their dependents)(Civilian Health and
9 Medical Program of the Uniformed Services)(CHAMPUS). For purposes of 10 U.S.C. section
10 1071 et seq., "uniformed services" means the armed forces and the commissioned corps of the
11 national oceanic and atmospheric administration and of the public health service;
- 12 (vi) A medical care program of the Indian Health Service or of a tribal organization;
- 13 (vii) A state health benefits risk pool;
- 14 (viii) A health plan offered under 5 U.S.C. section 8901 et seq., (Federal Employees
15 Health Benefits Program (FEHBP));
- 16 (ix) A public health plan, which for purposes of this chapter, means a plan established or
17 maintained by a state, county, or other political subdivision of a state that provides health
18 insurance coverage to individuals enrolled in the plan; or
- 19 (x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. section
20 2504(e)).
- 21 (2) A period of creditable coverage shall not be counted, with respect to enrollment of an
22 individual under a group health plan, if, after the period and before the enrollment date, the
23 individual experiences a significant break in coverage.
- 24 (j) "Dependent" means a spouse, an unmarried child under the age of nineteen (19) years,
25 an unmarried child who is a student under the age of twenty-five (25) years, and an unmarried
26 child of any age who is financially dependent upon, the parent and is medically determined to
27 have a physical or mental impairment which can be expected to result in death or which has
28 lasted or can be expected to last for a continuous period of not less than twelve (12) months.
- 29 (k) "Director" means the director of the department of business regulation.
- 30 (l) [Deleted by P.L. 2006, ch. 258, section 2, and P.L. 2006, ch. 296, section 2.]
- 31 (m) "Eligible employee" means an employee who works on a full-time basis with a
32 normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the
33 term shall also include an employee who works on a full-time basis with a normal work week of
34 anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this

1 eligibility criterion is applied uniformly among all of the employer's employees and without
2 regard to any health status-related factor. The term includes a self-employed individual, a sole
3 proprietor, a partner of a partnership, and may include an independent contractor, if the self-
4 employed individual, sole proprietor, partner, or independent contractor is included as an
5 employee under a health benefit plan of a small employer, but does not include an employee who
6 works on a temporary or substitute basis or who works less than seventeen and one-half (17.5)
7 hours per week. Any retiree under contract with any independently incorporated fire district is
8 also included in the definition of eligible employee. Persons covered under a health benefit plan
9 pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered
10 "eligible employees" for purposes of minimum participation requirements pursuant to section 27-
11 50-7(d)(9).

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

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

17 (p) "Family composition" means:

- 18 (1) Enrollee;
19 (2) Enrollee, spouse and children;
20 (3) Enrollee and spouse; or
21 (4) Enrollee and children.

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

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

30 (s) (1) "Group health plan" means an employee welfare benefit plan as defined in section
31 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the
32 extent that the plan provides medical care, as defined in subsection (y) of this section, and
33 including items and services paid for as medical care to employees or their dependents as defined
34 under the terms of the plan directly or through insurance, reimbursement, or otherwise.

1 (2) For purposes of this chapter:

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

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

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

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

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

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

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

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

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

29 (iii) Liability insurance, including general liability insurance and automobile liability
30 insurance;

31 (iv) Workers' compensation or similar insurance;

32 (v) Automobile medical payment insurance;

33 (vi) Credit-only insurance;

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

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

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

7 (i) Limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

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

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

33 (A) A statement from the carrier certifying that policies or certificates described in this
34 paragraph are being offered and marketed as supplemental health insurance and not as a substitute

1 for hospital or medical expense insurance or major medical expense insurance; and

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

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

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

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

12 (1) Health status;

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

14 (3) Claims experience;

15 (4) Receipt of health care;

16 (5) Medical history;

17 (6) Genetic information;

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

20 (8) Disability.

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

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

26 (i) Who meets each of the following provisions:

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

29 (B) The individual lost creditable coverage as a result of cessation of employer
30 contribution, termination of employment or eligibility, reduction in the number of hours of
31 employment, involuntary termination of creditable coverage, or death of a spouse, divorce or
32 legal separation, or the individual and/or dependents are determined to be eligible for RItCare
33 under chapter 5.1 of title 40 or chapter 12.3 of title 42 or for RItShare under chapter 8.4 of title
34 40; and

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

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

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

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

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

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

14 (vii) Who meets the requirements for special enrollment pursuant to section 27-50-7 or
15 27-50-8.

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

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

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

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

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

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

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

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

34 (cc) (1) "Preexisting condition" means a condition, regardless of the cause of the

1 condition, for which medical advice, diagnosis, care, or treatment was recommended or received
2 during the six (6) months immediately preceding the enrollment date of the coverage.

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

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

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

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

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

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

21 (hh) "Risk adjustment mechanism" means the mechanism established pursuant to section
22 27-50-16.

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

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

31 (kk) "Small employer" means, except for its use in section 27-50-7, any person, firm,
32 corporation, partnership, association, political subdivision, or self-employed individual that is
33 actively engaged in business including, but not limited to, a business or a corporation organized
34 under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of

1 another state that, on at least fifty percent (50%) of its working days during the preceding
2 calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week
3 of thirty (30) or more hours, the majority of whom were employed within this state, and is not
4 formed primarily for purposes of buying health insurance and in which a bona fide employer-
5 employee relationship exists. In determining the number of eligible employees, companies that
6 are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation
7 by this state, shall be considered one employer. Subsequent to the issuance of a health benefit
8 plan to a small employer and for the purpose of determining continued eligibility, the size of a
9 small employer shall be determined annually. Except as otherwise specifically provided,
10 provisions of this chapter that apply to a small employer shall continue to apply at least until the
11 plan anniversary following the date the small employer no longer meets the requirements of this
12 definition. The term small employer includes a self-employed individual.

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

18 (mm) "Wellness health benefit plan" means a plan developed pursuant to section 27-50-
19 10.

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

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

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

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

28 **27-50-4. Applicability and scope.** -- (a) This chapter applies to any health benefit plan
29 that provides coverage to the employees of a small employer in this state, [whether issued directly](#)
30 [by a carrier or through a trust, association, or other intermediary, and regardless of issuance or](#)
31 [delivery of the policy](#), if any of the following conditions are met:

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

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

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

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

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

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

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

21 SECTION 2. Section 27-18.5-2 of the General Laws in Chapter 27-18.5 entitled
22 "Individual Health Insurance Coverage" is hereby amended to read as follows:

23 **27-18.5-2. Definitions.** -- The following words and phrases as used in this chapter have
24 the following meanings unless a different meaning is required by the context:

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

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

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

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

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

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

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

4 (vii) Has a constitution and bylaws; and

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

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

7 (i) Section 4980(B) of the Internal Revenue Code of 1986, 26 U.S.C. section 4980B,
8 other than subsection (f)(1) of that section insofar as it relates to pediatric vaccines;

9 (ii) Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of
10 1974, 29 U.S.C. section 1161 et seq., other than Section 609 of that act, 29 U.S.C. section 1169;
11 or

12 (iii) Title XXII of the United States Public Health Service Act, 42 U.S.C. section 300bb-
13 1 et seq.;

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

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

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

18 (i) For whom, as of the date on which the individual seeks coverage under this chapter,
19 the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose
20 most recent prior creditable coverage was under a group health plan, a governmental plan
21 established or maintained for its employees by the government of the United States or by any of
22 its agencies or instrumentalities, or church plan (as defined by the Employee Retirement Income
23 Security Act of 1974, 29 U.S.C. section 1001 et seq.);

24 (ii) Who is not eligible for coverage under a group health plan, part A or part B of title
25 XVIII of the Social Security Act, 42 U.S.C. section 1395c et seq. or 42 U.S.C. section 1395j et
26 seq., or any state plan under title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq.
27 (or any successor program), and does not have other health insurance coverage;

28 (iii) With respect to whom the most recent coverage within the coverage period was not
29 terminated based on a factor described in section 27-18.5-4(b)(relating to nonpayment of
30 premiums or fraud);

31 (iv) If the individual had been offered the option of continuation coverage under a
32 COBRA continuation provision, or under chapter 19.1 of this title or under a similar state
33 program of this state or any other state, who elected the coverage; and

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

1 continuation coverage under the provision or program;

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

7 (7) "Health insurance carrier" or "carrier" means any entity subject to the insurance laws
8 and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to
9 contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care
10 services, including, without limitation, an insurance company offering accident and sickness
11 insurance, a health maintenance organization, a nonprofit hospital, medical or dental service
12 corporation, or any other entity providing a plan of health insurance or health benefits by which
13 health care services are paid or financed for an eligible individual or his or her dependents by
14 such entity on the basis of a periodic premium, paid directly or through an association, trust, or
15 other intermediary, and issued, renewed, or delivered within or without Rhode Island to cover a
16 natural person who is a resident of this state, including a certificate issued to a natural person
17 which evidences coverage under a policy or contract issued to a trust or association;

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

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

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

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

26 (C) Liability insurance, including general liability insurance and automobile liability
27 insurance;

28 (D) Workers' compensation or similar insurance;

29 (E) Automobile medical payment insurance;

30 (F) Credit-only insurance;

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

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

1 (I) Short term limited duration insurance;

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

5 (A) Limited scope dental or vision benefits;

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

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

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

16 (A) Coverage only for a specified disease or illness; or

17 (B) Hospital indemnity or other fixed indemnity insurance; and

18 (v) "Health insurance coverage" does not include the following if it is offered as a
19 separate policy, certificate, or contract of insurance:

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

22 (B) Coverage supplemental to the coverage provided under 10 U.S.C. section 1071 et
23 seq.; and

24 (C) Similar supplemental coverage provided to coverage under a group health plan;

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

26 (i) Health status;

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

28 (iii) Claims experience;

29 (iv) Receipt of health care;

30 (v) Medical history;

31 (vi) Genetic information;

32 (vii) Evidence of insurability, including conditions arising out of acts of domestic
33 violence; and

34 (viii) Disability;

1 (10) "Individual market" means the market for health insurance coverage offered to
2 individuals other than in connection with a group health plan;

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

7 (12) "Preexisting condition" means, with respect to health insurance coverage, a
8 condition (whether physical or mental), regardless of the cause of the condition, that was present
9 before the date of enrollment for the coverage, for which medical advice, diagnosis, care, or
10 treatment was recommended or received within the six (6) month period ending on the enrollment
11 date. Genetic information shall not be treated as a preexisting condition in the absence of a
12 diagnosis of the condition related to that information.

13 SECTION 3. This act shall take effect upon passage.

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LC00285
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE

1 This act would grant the commissioner of health insurance the authority to enforce the
2 laws relating to small group and individual market health insurance against insurance companies
3 offering insurance through out of state trusts and associations.

4 This act would take effect upon passage.

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