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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2006

A N A C T

RELATING TO INSURANCE -- THE RHODE ISLAND HEALTH CARE AFFORDABILITY ACT OF 2006 -- PART I - SMALL GROUP AND INDIVIDUAL HEALTH INSURANCE

Introduced By: Representatives Naughton, Crowley, Gallison, Slater, and Pacheco

Date Introduced: January 31, 2006

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. This act shall be known and may be cited as "The Rhode Island Health Care
2 Affordability Act of 2006 – Part I. An Act Relating to Small Group and Individual Health
3 Insurance."
4 SECTION 2. Sections 27-50-3, 27-50-5, 27-50-7 and 27-50-10 of the General Laws in
5 Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" are hereby amended
6 to read as follows:
7 **27-50-3. Definitions. --** (a) "Actuarial certification" means a written statement signed by
8 a member of the American Academy of Actuaries or other individual acceptable to the director
9 that a small employer carrier is in compliance with the provisions of section 27-50-5, based upon
10 the person's examination and including a review of the appropriate records and the actuarial
11 assumptions and methods used by the small employer carrier in establishing premium rates for
12 applicable health benefit plans.
13 (b) "Adjusted community rating" means a method used to develop a carrier's premium
14 which spreads financial risk across the carrier's entire small group population in accordance with
15 the requirements in section 27-50-5.
16 (c) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
17 through one or more intermediaries controls or is controlled by, or is under common control with,
18 a specified entity or person.

1 (d) "Affiliation period" means a period of time that must expire before health insurance
2 coverage provided by a carrier becomes effective, and during which the carrier is not required to
3 provide benefits.
4 (e) "Bona fide association" means, with respect to health benefit plans offered in this
5 state, an association which:
6 (1) Has been actively in existence for at least five (5) years;
7 (2) Has been formed and maintained in good faith for purposes other than obtaining
8 insurance;
9 (3) Does not condition membership in the association on any health-status related factor
10 relating to an individual (including an employee of an employer or a dependent of an employee);
11 (4) Makes health insurance coverage offered through the association available to all
12 members regardless of any health status-related factor relating to those members (or individuals
13 eligible for coverage through a member);
14 (5) Does not make health insurance coverage offered through the association available
15 other than in connection with a member of the association;
16 (6) Is composed of persons having a common interest or calling;
17 (7) Has a constitution and bylaws; and
18 (8) Meets any additional requirements that the director may prescribe by regulation.
19 (f) "Carrier" or "small employer carrier" means all entities licensed, or required to be
20 licensed, in this state that offer health benefit plans covering eligible employees of one or more
21 small employers pursuant to this chapter. For the purposes of this chapter, carrier includes an
22 insurance company, a nonprofit hospital or medical service corporation, a fraternal benefit
23 society, a health maintenance organization as defined in chapter 41 of this title or as defined in
24 chapter 62 of title 42, or any other entity providing a plan of health insurance or health benefits
25 subject to state insurance regulation.
26 (g) "Church plan" has the meaning given this term under section 3(33) of the Employee
27 Retirement Income Security Act of 1974 [29 U.S.C. section 1002(33)_.
28 (h) "Control" is defined in the same manner as in chapter 35 of this title.
29 (i) (1) "Creditable coverage" means, with respect to an individual, health benefits or
30 coverage provided under any of the following:
31 (i) A group health plan;
32 (ii) A health benefit plan;
33 (iii) Part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. section 1395c
34 et seq., or 42 U.S.C. section 1395j et seq., (Medicare);

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

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

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

(vii) A state health benefits risk pool;

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

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

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

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

(j) "Dependent" means a spouse, an unmarried child under the age of nineteen (19) years, an unmarried child who is a ~~full-time~~ student under the age of twenty-five (25) years and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

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

(l) ~~"Economy health plan" means a lower cost health benefit plan developed pursuant to the provisions of section 27-50-10.~~

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

1 employed individual, sole proprietor, partner, or independent contractor is included as an
2 employee under a health benefit plan of a small employer, but does not include an employee who
3 works on a temporary or substitute basis or who works less than seventeen and one-half (17.5)
4 hours per week. Any retiree under contract with any independently incorporated fire district is
5 also included in the definition of eligible employee. Persons covered under a health benefit plan
6 pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered
7 "eligible employees" for purposes of minimum participation requirements pursuant to section 27-
8 50-7(d)(9).
9 (n) "Enrollment date" means the first day of coverage or, if there is a waiting period, the
10 first day of the waiting period, whichever is earlier.
11 (o) "Established geographic service area" means a geographic area, as approved by the
12 director and based on the carrier's certificate of authority to transact insurance in this state, within
13 which the carrier is authorized to provide coverage.
14 (p) "Family composition" means:
15 (1) Enrollee;
16 (2) Enrollee, spouse and children;
17 (3) Enrollee and spouse; or
18 (4) Enrollee and children.
19 (q) "Genetic information" means information about genes, gene products, and inherited
20 characteristics that may derive from the individual or a family member. This includes information
21 regarding carrier status and information derived from laboratory tests that identify mutations in
22 specific genes or chromosomes, physical medical examinations, family histories, and direct
23 analysis of genes or chromosomes.
24 (r) "Governmental plan" has the meaning given the term under section 3(32) of the
25 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(32), and any federal
26 governmental plan.
27 (s) (1) "Group health plan" means an employee welfare benefit plan as defined in section
28 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the
29 extent that the plan provides medical care, as defined in subsection (y) of this section, and
30 including items and services paid for as medical care to employees or their dependents as defined
31 under the terms of the plan directly or through insurance, reimbursement, or otherwise.
32 (2) For purposes of this chapter:
33 (i) Any plan, fund, or program that would not be, but for PHSA Section 2721(e), 42
34 U.S.C. section 300gg(e), as added by P.L. 104-191, an employee welfare benefit plan and that is

established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph (ii) of this subdivision, as an employee welfare benefit plan that is a group health plan;

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

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

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

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

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

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

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

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

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

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

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

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

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

(i) Limited scope dental or vision benefits;

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

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

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

(B) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums

1 vary by age or other factors) charged for those policies and certificates in this state; and

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

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

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

9 (1) Health status;

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

11 (3) Claims experience;

12 (4) Receipt of health care;

13 (5) Medical history;

14 (6) Genetic information;

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

17 (8) Disability.

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

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

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

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

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

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

34 (ii) If, where provided for in contract or where otherwise provided in state law, the

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

1 diagnosis, care, or treatment was recommended or received for the first time while the covered
2 person held creditable coverage and that was a covered benefit under the health benefit plan,
3 provided that the prior creditable coverage was continuous to a date not more than ninety (90)
4 days prior to the enrollment date of the new coverage.
5 (3) Genetic information shall not be treated as a condition under subdivision (1) of this
6 subsection for which a preexisting condition exclusion may be imposed in the absence of a
7 diagnosis of the condition related to the information.
8 (dd) "Premium" means all moneys paid by a small employer and eligible employees as a
9 condition of receiving coverage from a small employer carrier, including any fees or other
10 contributions associated with the health benefit plan.
11 (ee) "Producer" means any insurance producer licensed under chapter 2.4 of this title.
12 (ff) "Rating period" means the calendar period for which premium rates established by a
13 small employer carrier are assumed to be in effect.
14 (gg) "Restricted network provision" means any provision of a health benefit plan that
15 conditions the payment of benefits, in whole or in part, on the use of health care providers that
16 have entered into a contractual arrangement with the carrier pursuant to provide health care
17 services to covered individuals.
18 (hh) "Risk adjustment mechanism" means the mechanism established pursuant to section
19 27-50-16.
20 (ii) "Self-employed individual" means an individual or sole proprietor who derives a
21 substantial portion of his or her income from a trade or business through which the individual or
22 sole proprietor has attempted to earn taxable income and for which he or she has filed the
23 appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.
24 (jj) "Significant break in coverage" means a period of ninety (90) consecutive days
25 during all of which the individual does not have any creditable coverage, except that neither a
26 waiting period nor an affiliation period is taken into account in determining a significant break in
27 coverage.
28 (kk) "Small employer" means, except for its use in section 27-50-7, any person, firm,
29 corporation, partnership, association, political subdivision, or self-employed individual that is
30 actively engaged in business including, but not limited to, a business or a corporation organized
31 under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of
32 another state that, on at least fifty percent (50%) of its working days during the preceding
33 calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week
34 of thirty (30) or more hours, the majority of whom were employed within this state, and is not

formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term small employer includes a self-employed individual.

~~(ll) "Standard health benefit plan" means a health benefit plan developed pursuant to the provisions of section 27-50-10.~~

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

~~(nn) "Affordable health benefit plan" means a health benefit plan that is designed to promote health, i.e. disease prevention, wellness, disease management, preventive care, and/or similar health and wellness programs; that is actively marketed by a carrier in accordance with this chapter; and that may be modified or terminated by a carrier in accordance with section 27-50-6.~~

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

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

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

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

(i) Age;

(ii) Gender; and

(iii) Family composition.

(2) A small employer carrier who as of June 1, 2000, varied rates by health status may

vary the adjusted community rates for health status by ten percent (10%), provided that the resulting rates comply with the other requirements of this section, including subdivision (5) of this subsection.

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

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

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

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

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

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

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

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

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

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

The calculation of premium discounts, rebates, or modifications to otherwise applicable copayments or deductibles for affordable health benefit plans shall be made in a manner

1 consistent with accepted actuarial standards and based on actual or reasonably anticipated small
2 employer claims experience. As used in the preceding sentence, "accepted actuarial standards"
3 includes actuarially appropriate use of relevant data from outside the claims experience of small
4 employers covered by affordable health plans, including, but not limited to, experience derived
5 from the large group market, as this term is defined in section 27-18.6-2(20).

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

10 (f) The director may establish regulations to implement the provisions of this section and
11 to assure that rating practices used by small employer carriers are consistent with the purposes of
12 this chapter, including regulations that assure that differences in rates charged for health benefit
13 plans by small employer carriers are reasonable and reflect objective differences in plan design or
14 coverage (not including differences due to the nature of the groups assumed to select particular
15 health benefit plans or separate claim experience for individual health benefit plans).

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

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

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

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

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

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

31 (2) Each small employer carrier shall file with the director annually on or before March
32 15 an actuarial certification certifying that the carrier is in compliance with this chapter and that
33 the rating methods of the small employer carrier are actuarially sound. The certification shall be
34 in a form and manner, and shall contain the information, specified by the director. A copy of the

certification shall be retained by the small employer carrier at its principal place of business.

(3) A small employer carrier shall make the information and documentation described in subdivision (1) of this subsection available to the director upon request. Except in cases of violations of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

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

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

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

(b) (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state including ~~at least two (2) health benefit plans. One health benefit plan offered by each small employer carrier shall be a standard health benefit plan, and one plan shall be an economy~~ a wellness health benefit plan. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to any small employer not currently receiving a health benefit plan from the small employer carrier.

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

enrollment date of the new coverage.

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

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

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

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

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

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

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

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

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

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

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) ~~Except as provided in subsection (iii), herein for~~ For health benefit plans issued or
24 renewed on or after October 1, 2000, a small employer carrier shall not require a minimum
25 participation level greater than~~:~~ seventy-five percent (75%) of eligible employees.
26 ~~(A) One hundred percent (100%) of eligible employees working for groups of ten (10) or~~
27 ~~less employees; and~~
28 ~~(B) Seventy five percent (75%) of eligible employees working for groups with more~~
29 ~~than ten (10) employees.~~
30 ~~(iii) From October 1, 2004 until October 1, 2006, a small employer carrier shall not~~
31 ~~require a minimum participation level greater than seventy five percent (75%) of eligible~~
32 ~~employees working for groups with ten (10) or less employees.~~
33 ~~(iv)~~ (iii) In applying minimum participation requirements with respect to a small
34 employer, a small employer carrier shall not consider employees or dependents who have

creditable coverage in determining whether the applicable percentage of participation is met.

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

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

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

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

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

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

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

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

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

(3) A small employer carrier shall apply the provisions of this subsection uniformly to all small employers without regard to the claims experience of a small employer and its employees

and their dependents or any health status-related factor relating to the employees and their dependents.

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

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

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

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

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

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

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

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

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

27-50-10. ~~Standard and economy health benefit plans.~~ Wellness health benefit plan. -- (a) No provision contained in this chapter prohibits the sale of health benefit plans which differ from the ~~standard and economy~~ wellness health benefit plans provided for in this section. ~~The standard and economy health benefit plans are exempted from the mandated benefits as provided for in section 27-50-13.~~

~~(b) (1) The standard health benefit plan shall include:~~

~~(i) Inpatient hospital care up to twenty (20) days per year;~~

~~(ii) Outpatient hospital care including, but not limited to, surgery and anesthesia, preadmission testing, radiation therapy, and chemotherapy;~~

~~(iii) Emergency care through emergency room care and emergency admissions to a hospital, excluding care for conditions that are not lifethreatening;~~

~~(iv) Pediatric care and well baby exams, with up to six (6) visits in a child's first year, and childhood immunizations until age eight (8);~~

~~(v) Physician office visits or community health center visits for primary or sick care, up to four (4) visits per year, and laboratory fees, surgery and anesthesia, diagnostic x-rays, and physician care in a hospital inpatient or outpatient setting;~~

~~(vi) Maternity care including prenatal office visits, care in the hospital for mother, and child and newborn nursery care;~~

~~(vii) Newborn metabolic and sickle cell screening, mammography, and pap tests;~~

~~(viii) Psychiatric care and substance abuse care up to twenty (20) outpatient visits per year; inpatient psychiatric care and inpatient substance abuse care shall be included in the twenty (20) days provided by paragraph (i) of this subdivision. The lifetime substance abuse benefit is a maximum of forty-five (45) inpatient days; and~~

~~(ix) Home nursing care in lieu of or to reduce hospital length of stay, up to twenty (20) visits per year.~~

~~(2) The term "physician" includes doctors of medicine, osteopathy, and optometry.~~

~~(3) Standard health care benefits include the following copayments:~~

~~(i) A twenty percent (20%) copayment will be charged for all services except for inpatient hospitalization;~~

~~(ii) A two hundred dollar ($200) per day copayment will be charged for each day of inpatient hospitalization in any acute care hospital or psychiatric care or substance abuse care treatment facility;~~

~~(iii) A twenty percent (20%) copayment will be charged for any covered emergency room visit, except that when a patient is admitted to the hospital as an inpatient, the copayment shall be waived; and~~

~~(iv) There shall be an annual out of pocket stop loss of two thousand five hundred dollars ($2,500) per individual and five thousand dollars ($5,000) per family. After the stop loss amount has been reached, no additional copayments shall be charged until the beginning of the next contract year.~~

~~(4) Cost containment mechanisms may be used for all services to include, but not be limited to, the following:~~

~~(i) Primary care gatekeepers;~~

~~(ii) Preadmission certification;~~

~~(iii) Mandatory second opinion prior to elective surgery;~~

~~(iv) Preauthorization for specified services;~~

~~(v) Concurrent utilization review and management;~~

~~(vi) Discharge planning for hospital care;~~

~~(vii) Design and implementation of a structure of copayments as described in this chapter; and~~

~~(viii) Less costly alternatives to inpatient care.~~

~~(c) (1) The economy health benefit plan shall include:~~

~~(i) Inpatient hospital care up to twenty (20) days per year;~~

~~(ii) Outpatient hospital care including, but not limited to, surgery and anesthesia, preadmission testing, radiation therapy, and chemotherapy;~~

~~(iii) Emergency care through emergency room care and emergency admissions to a hospital excluding care for conditions that are not life threatening;~~

~~(iv) Pediatric care and well baby exams, with up to six (6) visits in a child's first year, and childhood immunizations until age eight (8);~~

~~(v) Physician office visits or community health center visits for primary or sick care, up to four (4) visits per year, and laboratory fees, surgery and anesthesia, diagnostic x-rays, and physician care in a hospital inpatient or outpatient setting;~~

~~(vi) Maternity care including prenatal office visits, care in the hospital for mother and child, and newborn nursery care;~~

~~(vii) Newborn metabolic and sickle cell screening, mammography, and pap tests;~~

~~(viii) Psychiatric care and substance abuse care up to twenty (20) outpatient visits per year; inpatient psychiatric care and inpatient substance abuse care shall be included in the twenty (20) days provided by paragraph (i) of this subdivision. The lifetime substance abuse benefit shall be a maximum of forty-five (45) inpatient days; and~~

~~(ix) Home nursing care in lieu of or to reduce hospital length of stay, up to twenty (20) visits per year.~~

~~(2) The term "physician" includes doctors of medicine, osteopathy, and optometry;~~

~~(3) Economy health care benefits include the following copayments:~~

~~(i) A twenty percent (20%) copayment shall be charged for any covered service contained in paragraphs (1)(iv), (1)(vi), (1)(vii), and (1)(ix) of this subsection;~~

~~(ii) A three hundred dollar ($300) per day copayment will be charged for each day of~~

~~inpatient hospitalization in any acute care hospital or psychiatric care or substance abuse care treatment facility;~~

~~(iii) A fifty percent (50%) copayment shall be charged for any covered service contained in paragraphs (1)(ii), (1)(iii), (1)(v), and (1)(viii) of this subsection, except that when a patient is admitted to the hospital from the emergency room, the copayment shall be waived; and~~

~~(iv) There shall be an annual out of pocket stop loss of two thousand five hundred dollars ($2,500) per individual and five thousand dollars ($5,000) per family. After the stop-loss amount has been reached, no additional copayments shall be charged until the beginning of the next contract year.~~

~~(4) Cost containment mechanisms may be used for all services to include, but not be limited to, the following:~~

~~(i) Primary care gatekeepers;~~

~~(ii) Preadmission certification;~~

~~(iii) Mandatory second opinion prior to elective surgery;~~

~~(iv) Preauthorization for specified services;~~

~~(v) Concurrent utilization review and management;~~

~~(vi) Discharge planning for hospital care;~~

~~(vii) Design and implementation of a structure of copayments as described in this chapter; and~~

~~(viii) Less costly alternatives to inpatient care.~~

~~(d) [Deleted by P.L. 2003, ch. 120, section 1 and by P.L. 2003, ch. 286, section 1.]~~

(b) The wellness health benefit plan shall be determined by regulations promulgated by the office of health insurance commissioner (OHIC). The OHIC shall develop the criteria for the wellness health benefit plan, including, but not limited to, benefit levels, cost-sharing levels, exclusions, and limitations, in accordance with the following:

(1)(i) The OHIC shall form an advisory committee to include representatives of employers, health insurance brokers, local chambers of commerce, and consumers who pay directly for individual health insurance coverage.

(ii) The advisory committee shall make recommendations to the OHIC concerning the following:

(A) The wellness health benefit plan requirements document. This document shall be disseminated to all Rhode Island small group and individual market health plans for responses, and shall include, at a minimum, the benefit limitations and maximum cost sharing levels for the wellness health benefit plan. If the wellness health benefit product requirements document is not

created by November 1, 2006, it will be determined by regulations promulgated by the OHIC.

(B) The wellness health benefit plan design. The health plans shall bring proposed wellness health plan designs to the advisory committee for review on or before January 1, 2007. The advisory committee shall review these proposed designs and provide recommendations to the health plans and the commissioner regarding the final wellness plan design to be approved by the commissioner in accordance with subsection 27-50-5(h)(4), and as specified in regulations promulgated by the commissioner on or before March 1, 2007.

(2) Set a target for the average annualized individual premium rate for the wellness health benefit plan to be less than ten percent (10%) of the average annual statewide wage, as reported by the Rhode Island department of labor and training, in their report entitled "Quarterly Census of Rhode Island Employment and Wages." In the event that this report is no longer available, or the OHIC determines that is no longer appropriate for the determination of maximum annualized premium, an alternative method shall be adopted in regulation by the OHIC. The maximum annualized individual premium rate shall be determined no later than August 1st of each year, to be applied to the subsequent calendar year premium rates.

(3) Ensure that the wellness health benefit plan creates appropriate incentives for employers, providers, health plans and consumers to, among other things:

(i) focus on primary care, prevention and wellness;

(ii) actively manage the chronically ill population;

(iii) use the least cost, most appropriate setting; and

(iv) use evidence based, quality care.

(4) To the extent possible, the health plans may be permitted to utilize existing products to meet the objectives of this section.

(5) The plan shall be made available in accordance with title 27, chapter 50 as required by regulation on or before May 1, 2007.

SECTION 3 Chapter 27-50 of the General Laws entitled "Small Employer Health Insurance Availability Act" is hereby amended by adding thereto the following section:

27-50-12.1. Renewal rating. -- To ensure ease of understanding of renewal rate calculation and related information, the health insurance commissioner may, by regulation, prescribe the presentation formats for delivery of renewal rates to small employers.

SECTION 4. Section 27-50-13 of the General Laws in Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" is hereby repealed in its entirety:

~~**27-50-13. Waiver of certain state laws. --** No law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization, or inclusion of a specific~~

~~category of licensed health care practitioner, applies to an economy or standard health benefit plan delivered or issued for delivery to small employers in this state pursuant to this chapter. Notwithstanding the foregoing, the benefits for mastectomy treatment mandated in sections 27-18-39, 27-19-34 and 27-41-43 shall be added to the benefits in section 27-50-10 for both the standard and economy health benefit plans.~~

SECTION 5. Chapter 27-18.5 of the General Laws entitled "Individual Health Insurance Coverage" is hereby amended by adding thereto the following section:

27-18.5-8. ~~**Direct wellness health benefit plan. –**~~ **Wellness health benefit plan. -** All carriers that offer health insurance in the individual market shall actively market and offer the wellness health direct benefit plan to eligible individuals. The wellness health direct benefit plan shall be determined by regulation promulgated by the office of the health insurance commissioner (OHIC). The OHIC shall develop the criteria for the direct wellness health benefit plan, including, but not limited to, benefit levels, cost sharing levels, exclusions and limitations in accordance with the following:

(a) Form and utilize an advisory committee in accordance with subsection 27-50-10(5).

(b) Set a target for the average annualized individual premium rate for the direct wellness health benefit plan to be less than ten percent (10%) of the average annual statewide wage, dependent upon the availability of reinsurance funds, as reported by the Rhode Island department of labor and training, in their report entitled "Quarterly Census of Rhode Island Employment and Wages." In the event that this report is no longer available, or the OHIC determines that is no longer appropriate for the determination of maximum annualized premium, an alternative method shall be adopted in regulation by the OHIC. The maximum annualized individual premium rate shall be determined no later than August 1st of each year, to be applied to the subsequent calendar year premiums rates.

(c) Ensure that the direct wellness health benefit plan creates appropriate incentives for employers, providers, health plans and consumers to, among other things:

(1) focus on primary care, prevention and wellness;

(2) actively manage the chronically ill population;

(3) use the least cost, most appropriate setting; and

(4) use evidence based, quality care.

(d) The plan shall be made available in accordance with title 27, chapter 18.5 as required by regulation on or before May 1, 2007.

1 SECTION 6. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N   A C T

RELATING TO INSURANCE -- THE RHODE ISLAND HEALTH CARE AFFORDABILITY ACT OF 2006 -- PART I - SMALL GROUP AND INDIVIDUAL HEALTH INSURANCE

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1 This act would create a wellness health benefit plan for residents of the state, and would
2 amend the small employer health insurance availability act to provide for this new affordable
3 health plan.
4 This act would take effect upon passage.

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SUBSTITUTE A

A N A C T

RELATING TO INSURANCE -- THE RHODE ISLAND HEALTH CARE AFFORDABILITY ACT OF 2006 -- PART I - SMALL GROUP AND INDIVIDUAL HEALTH INSURANCE

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LC00820/SUB A/2
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Presented by