

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2006

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A N A C T

RELATING TO INSURANCE -- THE RHODE ISLAND HEALTH CARE AFFORDABILITY
ACT OF 2006 PART III -- COVERAGE OF DEPENDENT CHILDREN

Introduced By: Representatives E Coderre, Kennedy, and Naughton

Date Introduced: February 08, 2006

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18.6-2 of the General Laws in Chapter 27-18.6 entitled "Large
2 Groups Health Insurance Coverage" is hereby amended to read as follows:

3 **27-18.6-2. Definitions.** -- The following words and phrases as used in this chapter have
4 the following meanings unless a different meaning is required by the context:

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

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

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

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

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

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

1 employee);

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

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

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

8 (vii) Has a constitution and bylaws; and

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

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

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

13 (ii) Part 6 of subtitle B of title 1 of the Employee Retirement Income Security Act of
14 1974, 29 U.S.C. section 1161 et seq., other than section 609 of that act, 29 U.S.C. section 1169;

15 or

16 (iii) Title XXII of the United States Public Health Service Act, 42 U.S.C. section 300bb-
17 1 et seq.;

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

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

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

26 ~~(8)~~ (7) "Director" means the director of the department of business regulation;

27 ~~(9)~~ (8) "Employee" has the meaning given that term under section 3(6) of the Employee
28 Retirement Income Security Act of 1974, 29 U.S.C. section 1002(6);

29 ~~(10)~~ (9) "Employer" has the meaning given that term under section 3(5) of the Employee
30 Retirement Income Security Act of 1974, 29 U.S.C. section 1002(5), except that the term includes
31 only employers of two (2) or more employees;

32 ~~(11)~~ (10) "Enrollment date" means, with respect to an individual covered under a group
33 health plan or health insurance coverage, the date of enrollment of the individual in the plan or
34 coverage or, if earlier, the first day of the waiting period for the enrollment;

1 ~~(12)~~ (11) "Governmental plan" has the meaning given that term under section 3(32) of
2 the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(32), and includes
3 any governmental plan established or maintained for its employees by the government of the
4 United States, the government of any state or political subdivision of the state, or by any agency
5 or instrumentality of government;

6 ~~(13)~~ (12) "Group health insurance coverage" means, in connection with a group health
7 plan, health insurance coverage offered in connection with that plan;

8 ~~(14)~~ (13) "Group health plan" means an employee welfare benefits plan as defined in
9 section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section
10 1002(1), to the extent that the plan provides medical care and including items and services paid
11 for as medical care to employees or their dependents as defined under the terms of the plan
12 directly or through insurance, reimbursement or otherwise;

13 ~~(15)~~ (14) "Health insurance carrier" or "carrier" means any entity subject to the insurance
14 laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or
15 offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health
16 care services, including, without limitation, an insurance company offering accident and sickness
17 insurance, a health maintenance organization, a nonprofit hospital, medical or dental service
18 corporation, or any other entity providing a plan of health insurance, health benefits, or health
19 services;

20 ~~(16)~~ (15)(i) "Health insurance coverage" means a policy, contract, certificate, or
21 agreement offered by a health insurance carrier to provide, deliver, arrange for, pay for, or
22 reimburse any of the costs of health care services. Health insurance coverage does include short-
23 term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis,
24 except as otherwise specifically exempted in this definition;

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

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

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

30 (C) Liability insurance, including general liability insurance and automobile liability
31 insurance;

32 (D) Workers' compensation or similar insurance;

33 (E) Automobile medical payment insurance;

34 (F) Credit-only insurance;

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

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

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

8 (A) Limited scope dental or vision benefits;

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

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

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

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

20 (B) Hospital indemnity or other fixed indemnity insurance;

21 (v) "Health insurance coverage" does not include the following "supplemental, excepted
22 benefits" if offered as a separate policy, certificate, or contract of insurance:

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

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

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

28 ~~(17)~~ (16) "Health maintenance organization" ("HMO") means a health maintenance
29 organization licensed under chapter 41 of this title;

30 ~~(18)~~ (17) "Health status-related factor" means any of the following factors:

31 (i) Health status;

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

33 (iii) Claims experience;

34 (iv) Receipt of health care;

1 (v) Medical history;

2 (vi) Genetic information;

3 (vii) Evidence of insurability, including contributions arising out of acts of domestic
4 violence; and

5 (viii) Disability;

6 ~~(19)~~ (18) "Large employer" means, in connection with a group health plan with respect
7 to a calendar year and a plan year, an employer who employed an average of at least fifty-one
8 (51) employees on business days during the preceding calendar year and who employs at least
9 two (2) employees on the first day of the plan year. In the case of an employer which was not in
10 existence throughout the preceding calendar year, the determination of whether the employer is a
11 large employer shall be based on the average number of employees that is reasonably expected
12 the employer will employ on business days in the current calendar year;

13 ~~(20)~~ (19) "Large group market" means the health insurance market under which
14 individuals obtain health insurance coverage (directly or through any arrangement) on behalf of
15 themselves (and their dependents) through a group health plan maintained by a large employer;

16 ~~(21)~~ (20) "Late enrollee" means, with respect to coverage under a group health plan, a
17 participant or beneficiary who enrolls under the plan other than during:

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

19 (ii) A special enrollment period;

20 ~~(22)~~ (21) "Medical care" means amounts paid for:

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

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

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

27 ~~(23)~~ (22) "Network plan" means health insurance coverage offered by a health insurance
28 carrier under which the financing and delivery of medical care including items and services paid
29 for as medical care are provided, in whole or in part, through a defined set of providers under
30 contract with the carrier;

31 ~~(24)~~ (23) "Participant" has the meaning given such term under section 3(7) of the
32 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(7);

33 ~~(25)~~ (24) "Placed for adoption" means, in connection with any placement for adoption of
34 a child with any person, the assumption and retention by that person of a legal obligation for total

1 or partial support of the child in anticipation of adoption of the child. The child's placement with
2 the person terminates upon the termination of the legal obligation;

3 ~~(26)~~ (25) "Plan sponsor" has the meaning given that term under section 3(16)(B) of the
4 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(16)(B). "Plan
5 sponsor" also includes any bona fide association, as defined in this section;

6 ~~(27)~~ (26) "Preexisting condition exclusion" means, with respect to health insurance
7 coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the
8 condition was present before the date of enrollment for the coverage, whether or not any medical
9 advice, diagnosis, care or treatment was recommended or received before the date; and

10 ~~(28)~~ (27) "Waiting period" means, with respect to a group health plan and an individual
11 who is a potential participant or beneficiary in the plan, the period that must pass with respect to
12 the individual before the individual is eligible to be covered for benefits under the terms of the
13 plan.

14 SECTION 2. Section 27-18-59 of the General Laws in Chapter 27-18 entitled "Accident
15 and Sickness Insurance Policies" is hereby amended to read as follows:

16 **27-18-59. Termination of children's benefits.** -- (a) Every individual ~~or group~~ health
17 insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state and
18 every group health insurance contract, plan, or policy delivered, issued for delivery or renewed in
19 this state which provides medical coverage for dependent children that includes coverage for
20 physician services in a physician's office, and every policy which provides major medical or
21 similar comprehensive type coverage, except for supplemental policies which only provide
22 coverage for specified diseases and other supplemental policies, shall provide coverage of an
23 unmarried child under the age of nineteen (19) years, an unmarried child who is a student under
24 the age of twenty-five (25) years and who is financially dependent upon the parent and an
25 unmarried child of any age who is financially dependent upon the parent and medically
26 determined to have a physical or mental impairment which can be expected to result in death or
27 which has lasted or can be expected to last for a continuous period of not less than twelve (12)
28 months. Such contract, plan or policy shall also include a provision that policyholders shall
29 receive no less than thirty (30) days notice from the accident and sickness insurer that a child
30 covered as a dependent by the policy holder is about to lose his or her coverage as a result of
31 reaching the maximum age for a dependent child, and that the child will only continue to be
32 covered upon documentation being provided of current ~~college~~ full or part-time enrollment in a
33 post-secondary educational institution or that the child may purchase a conversion policy if he or
34 she is not ~~a college~~ an eligible student. Nothing in this section prohibits an accident and sickness

1 insurer from requiring a policyholder to annually provide proof of a child's current ~~college~~ full or
2 part-time enrollment in a post-secondary educational institution in order to maintain the child's
3 coverage. Provided, nothing in this section requires coverage inconsistent with the membership
4 criteria in effect under the policyholder's health benefits coverage.

5 (b) This section does not apply to insurance coverage providing benefits for: (1) hospital
6 confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare
7 supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other limited
8 benefit policies.

9 SECTION 3. Section 27-19-50 of the General Laws in Chapter 27-19 entitled "Nonprofit
10 Hospital Service Corporations" is hereby amended to read as follows:

11 **27-19-50. Termination of children's benefits.** -- (a) Every individual ~~or group~~ health
12 insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state and
13 every group health insurance contract, plan, or policy delivered, issued for delivery or renewed in
14 this state which provides medical coverage for dependent children that includes coverage for
15 physician services in a physician's office, and every policy which provides major medical or
16 similar comprehensive type coverage, except for supplemental policies which only provide
17 coverage for specified diseases and other supplemental policies, shall provide coverage of an
18 unmarried child under the age of nineteen (19) years, an unmarried child who is a student under
19 the age of twenty-five (25) years and who is financially dependent upon the parent and an
20 unmarried child of any age who is financially dependent upon the parent and medically
21 determined to have a physical or mental impairment which can be expected to result in death or
22 which has lasted or can be expected to last for a continuous period of not less than twelve (12)
23 months. Such contract, plan or policy shall also include a provision that policyholders shall
24 receive no less than thirty (30) days notice from the nonprofit hospital service corporation that a
25 child covered as a dependent by the policyholder is about to lose his or her coverage as a result of
26 reaching the maximum age for a dependent child and that the child will only continue to be
27 covered upon documentation being provided of current ~~college~~ full or part-time enrollment in a
28 post-secondary educational institution, or that the child may purchase a conversion policy if he or
29 she is not ~~a college~~ an eligible student.

30 (b) Nothing in this section prohibits a nonprofit hospital service corporation from
31 requiring a policyholder to annually provide proof of a child's current ~~college~~ full or part-time
32 enrollment in a post-secondary educational institution in order to maintain the child's coverage.
33 Provided, nothing in this section requires coverage inconsistent with the membership criteria in
34 effect under the policyholder's health benefits coverage.

1 SECTION 4. Section 27-20-45 of the General Laws in Chapter 27-20 entitled "Nonprofit
2 Medical Service Corporations" is hereby amended to read as follows:

3 **27-20-45. Termination of children's benefits.** -- (a) Every individual ~~or group~~ health
4 insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state and
5 every group health insurance contract, plan, or policy delivered, issued for delivery or renewed in
6 this state which provides medical coverage for dependent children that includes coverage for
7 physician services in a physician's office, and every policy which provides major medical or
8 similar comprehensive type coverage, except for supplemental policies which only provide
9 coverage for specified diseases and other supplemental policies, shall provide coverage of an
10 unmarried child under the age of nineteen (19) years, an unmarried child who is a student under
11 the age of twenty-five (25) years and who is financially dependent upon the parent and an
12 unmarried child of any age who is financially dependent upon the parent and medically
13 determined to have a physical or mental impairment which can be expected to result in death or
14 which has lasted or can be expected to last for a continuous period of not less than twelve (12)
15 months. Such contract, plan or policy shall also include a provision that policyholders shall
16 receive no less than thirty (30) days notice from the nonprofit medical service corporation that a
17 child covered as a dependent by the policyholder is about to lose his or her coverage as a result of
18 reaching the maximum age for a dependent child and that the child will only continue to be
19 covered upon documentation being provided of current ~~college~~ full or part-time enrollment in a
20 post-secondary educational institution, or that the child may purchase a conversion policy if he or
21 she is not ~~a college~~ an eligible student.

22 (b) Nothing in this section prohibits a nonprofit medical service corporation from
23 requiring a policyholder to annually provide proof of a child's current ~~college~~ full or part-time
24 enrollment in a post-secondary educational institution in order to maintain the child's coverage.
25 Provided, nothing in this section requires coverage inconsistent with the membership criteria in
26 effect under the policyholder's health benefits coverage.

27 SECTION 5. Section 27-41-61 of the General Laws in Chapter 27-41 entitled "Health
28 Maintenance Organizations" is hereby amended to read as follows:

29 **27-41-61. Termination of children's benefits.** -- (a) Every individual ~~or group~~ health
30 insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state which
31 provides medical coverage for dependent children that includes coverage for physician services in
32 a physician's office, and every policy which provides major medical or similar comprehensive
33 type coverage, except for supplemental policies which only provide coverage for specified
34 diseases and other supplemental policies, shall provide coverage of an unmarried child under the

1 age of nineteen (19) years, an unmarried child who is a student under the age of twenty-five (25)
2 years and who is financially dependent upon the parent and an unmarried child of any age who is
3 financially dependent upon the parent and medically determined to have a physical or mental
4 impairment which can be expected to result in death or which has lasted or can be expected to last
5 for a continuous period of not less than twelve (12) months. Such contract, plan or policy shall
6 also include a provision that policyholders shall receive no less than thirty (30) days notice from
7 the health maintenance organization that a child is about to lose his or her coverage as a result of
8 reaching the maximum age for a dependent child and that the child will only continue to be
9 covered upon documentation being provided of current ~~college~~ full or part-time enrollment in a
10 post-secondary educational institution, or that the child may purchase a conversion policy if he or
11 she is not ~~a college~~ an eligible student.

12 (b) Nothing in this section prohibits a nonprofit health maintenance organization from
13 requiring a policyholder to annually provide proof of a child's current ~~college~~ full or part-time
14 enrollment in a post-secondary educational institution in order to maintain the child's coverage.
15 Provided, nothing in this section requires coverage inconsistent with the membership criteria in
16 effect under the policyholder's health benefits coverage.

17 SECTION 6. Section 27-50-3 of the General Laws in Chapter 27-50 entitled "Small
18 Employer Health Insurance Availability Act" is hereby amended to read as follows:

19 **27-50-3. Definitions.** -- (a) "Actuarial certification" means a written statement signed by
20 a member of the American Academy of Actuaries or other individual acceptable to the director
21 that a small employer carrier is in compliance with the provisions of section 27-50-5, based upon
22 the person's examination and including a review of the appropriate records and the actuarial
23 assumptions and methods used by the small employer carrier in establishing premium rates for
24 applicable health benefit plans.

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

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

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

34 (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.

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

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

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

27 (i) A group health plan;

28 (ii) A health benefit plan;

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

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

34 (v) 10 U.S.C. section 1071 et seq., (medical and dental care for members and certain

1 former members of the uniformed services, and for their dependents)(Civilian Health and
2 Medical Program of the Uniformed Services)(CHAMPUS). For purposes of 10 U.S.C. section
3 1071 et seq., "uniformed services" means the armed forces and the commissioned corps of the
4 national oceanic and atmospheric administration and of the public health service;

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

6 (vii) A state health benefits risk pool;

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

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

12 (x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. section
13 2504(e)).

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

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

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

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

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

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

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

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

13 (p) "Family composition" means:

14 (1) Enrollee;

15 (2) Enrollee, spouse and children;

16 (3) Enrollee and spouse; or

17 (4) Enrollee and children.

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

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

26 (s) (1) "Group health plan" means an employee welfare benefit plan as defined in section
27 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the
28 extent that the plan provides medical care, as defined in subsection (y) of this section, and
29 including items and services paid for as medical care to employees or their dependents as defined
30 under the terms of the plan directly or through insurance, reimbursement, or otherwise.

31 (2) For purposes of this chapter:

32 (i) Any plan, fund, or program that would not be, but for PHSA Section 2721(e), 42
33 U.S.C. section 300gg(e), as added by P.L. 104-191, an employee welfare benefit plan and that is
34 established or maintained by a partnership, to the extent that the plan, fund or program provides

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

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

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

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

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

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

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

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

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

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

27 (iv) Workers' compensation or similar insurance;

28 (v) Automobile medical payment insurance;

29 (vi) Credit-only insurance;

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

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

34 (3) "Health benefit plan" does not include the following benefits if they are provided

1 under a separate policy, certificate, or contract of insurance or are otherwise not an integral part
2 of the plan:

3 (i) Limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (1) Health status;

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

10 (3) Claims experience;

11 (4) Receipt of health care;

12 (5) Medical history;

13 (6) Genetic information;

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

16 (8) Disability.

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

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

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

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

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

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

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

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

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

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

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

10 (vii) Who meets the requirements for special enrollment pursuant to section 27-50-7 or
11 27-50-8.

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

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

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

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

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

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

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

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

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

33 (2) "Preexisting condition" does not mean a condition for which medical advice,
34 diagnosis, care, or treatment was recommended or received for the first time while the covered

1 person held creditable coverage and that was a covered benefit under the health benefit plan,
2 provided that the prior creditable coverage was continuous to a date not more than ninety (90)
3 days prior to the enrollment date of the new coverage.

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

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

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

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

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

17 (hh) "Risk adjustment mechanism" means the mechanism established pursuant to section
18 27-50-16.

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

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

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

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

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

11 (mm) "Waiting period" means, with respect to a group health plan and an individual who
12 is a potential enrollee in the plan, the period that must pass with respect to the individual before
13 the 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 (nn) "Affordable health benefit plan" means a health benefit plan that is designed to
17 promote health, i.e. disease prevention, wellness, disease management, preventive care, and/or
18 similar health and wellness programs; that is actively marketed by a carrier in accordance with
19 this chapter; and that may be modified or terminated by a carrier in accordance with section 27-
20 50-6.

21 SECTION 7. This act shall take effect on January 1, 2007.

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LC01015/SUB A/2
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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 III -- COVERAGE OF DEPENDENT CHILDREN

1 This act would amend the provisions regarding the termination of health insurance
2 benefits for children and would require insurance contracts to provide coverage of an unmarried
3 child of under the age of nineteen (19) years, an unmarried child who is a student under the age of
4 twenty-five (25) years and who is financially dependent upon the parent and an unmarried child
5 of any age who is financially dependent upon the parent and medically determined to have a
6 physical or mental impairment which can be expected to result in death or which has lasted or can
7 be expected to last for a continuous period of not less than twelve (12) months.

8 This act would take effect on January 1, 2007.

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LC01015/SUB A/
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