

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2006

A N A C T

**RELATING TO INSURANCE -- THE RHODE ISLAND HEALTHCARE AFFORDABILITY
ACT OF 2006 - PART VII - SMALL BUSINESSES**

Introduced By: Senators Roberts, Walaska, Perry, P Fogarty, and Algieri

Date Introduced: January 19, 2006

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Legislative Intent. It is the intent of the General Assembly to hereby create
2 The Rhode Island Affordable Health Plan Reinsurance Program to reduce the cost of health
3 insurance for qualified individuals and small employers.

4 SECTION 2. Section 27-18.5-1 of the General Laws in Chapter 27-18.5 entitled
5 "Individual Health Insurance Coverage" is hereby amended to read as follows:

6 **27-18.5-1. Purpose.** -- The purpose of this chapter is among other things, to insure
7 compliance of all policies, contracts, certificates, and agreements of individual health insurance
8 coverage offered or delivered in this state with the Health Insurance Portability and
9 Accountability Act of 1996 (P.L. 104-191).

10 SECTION 3 Section 27-18.5-2 of the General Laws in Chapter 27-18.5 entitled
11 "Individual Health Insurance Coverage" is hereby amended to read as follows:

12 **27-18.5-2. Definitions.** -- The following words and phrases as used in this chapter have
13 the following meanings unless a different meaning is required by the context:

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

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

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

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

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

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

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

9 (vii) Has a constitution and bylaws; and

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

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

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

14 (ii) Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of
15 1974, 29 U.S.C. section 1161 et seq., other than Section 609 of that act, 29 U.S.C. section 1169;
16 or

17 (iii) Title XXII of the United States Public Health Service Act, 42 U.S.C. section 300bb-
18 1 et seq.;

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

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

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

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

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

33 (iii) With respect to whom the most recent coverage within the coverage period was not
34 terminated based on a factor described in section 27-18.5-4(b)(relating to nonpayment of

1 premiums or fraud);

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

5 (v) Who, if the individual elected COBRA continuation coverage, has exhausted the
6 continuation coverage under the provision or program;

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

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

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

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

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

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

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

28 (D) Workers' compensation or similar insurance;

29 (E) Automobile medical payment insurance;

30 (F) Credit-only insurance;

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

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

1 (I) Short term limited duration insurance;

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

5 (A) Limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

26 (i) Health status;

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

28 (iii) Claims experience;

29 (iv) Receipt of health care;

30 (v) Medical history;

31 (vi) Genetic information;

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

34 (viii) Disability;

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

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

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

13 (13) "High-risk individuals" means those individuals who do not pass medical
14 underwriting standards, due to high health care needs or risks;

15 (14) "Wellness health benefit plan" means that health benefit plan offered in the
16 individual market pursuant to section 27-18.5-8; and

17 (15) "Commissioner" means the health insurance commissioner.

18 SECTION 4. Chapter 27-18.5 of the General Laws entitled "Individual Health Insurance
19 Coverage" is hereby amended by adding thereto the following section:

20 **27-18.5-8. Affordable health plan reinsurance program for individuals.** – (a) The
21 commissioner shall allocate funds from the affordable health plan reinsurance fund for the
22 affordable health reinsurance program.

23 (b) The affordable health reinsurance program for individuals shall only be available to
24 high-risk individuals as defined in section 27-18.5-2, and who purchase the direct wellness health
25 benefit plan pursuant to the provisions of this section. Eligibility shall be determined based on
26 state and federal income tax filings.

27 (c) The affordable health plan reinsurance shall be in the form of a carrier cost-sharing
28 arrangement, which encourages carriers to offer a discounted premium rate to participating
29 individuals, and whereby the reinsurance fund subsidizes the carriers' losses within a prescribed
30 corridor of risk as determined by regulation.

31 (d) The specific structure of the reinsurance arrangement shall be defined by regulations
32 promulgated by the commissioner.

33 (e) The commissioner shall determine total eligible enrollment under qualifying
34 individual health insurance contracts by dividing the funds available for distribution from the

1 reinsurance fund by the estimated per member annual cost of claims reimbursement from the
2 reinsurance fund.

3 (f) The commissioner shall suspend the enrollment of new individuals under qualifying
4 individual health insurance contracts if the director determines that the total enrollment reported
5 under such contracts is projected to exceed the total eligible enrollment, thereby resulting in
6 anticipated annual expenditures from the reinsurance fund in excess of ninety-five percent (95%)
7 of the total funds available for distribution from the fund.

8 (g) The commissioner shall provide the health maintenance organization, health insurers
9 and health plans with notification of any enrollment suspensions as soon as practicable after
10 receipt of all enrollment data.

11 (h) The premiums of qualifying individual health insurance contracts must be no more
12 than ninety percent (90%) of the actuarially-determined and commissioner approved premium for
13 this health plan without the reinsurance program assistance.

14 (i) The commissioner shall prepare periodic public reports in order to facilitate evaluation
15 and ensure orderly operation of the funds, including, but not limited to, an annual report of the
16 affairs and operations of the fund, containing an accounting of the administrative expenses
17 charged to the fund. Such reports shall be delivered to the co-chairs of the joint legislative
18 committee on health care oversight by March 1st of each year.

19 SECTION 5. Section 27-50-3 of the General Laws in Chapter 27-50 entitled "Small
20 Employer Health Insurance Availability Act" is hereby amended to read as follows:

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

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

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

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

1 provide benefits.

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

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

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

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

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

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

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

15 (7) Has a constitution and bylaws; and

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

17 (f) "Carrier" or "small employer carrier" means all entities licensed, or required to be
18 licensed, in this state that offer health benefit plans covering eligible employees of one or more
19 small employers pursuant to this chapter. For the purposes of this chapter, carrier includes an
20 insurance company, a nonprofit hospital or medical service corporation, a fraternal benefit
21 society, a health maintenance organization as defined in chapter 41 of this title or as defined in
22 chapter 62 of title 42, or any other entity providing a plan of health insurance or health benefits
23 subject to state insurance regulation.

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

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

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

29 (i) A group health plan;

30 (ii) A health benefit plan;

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

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

1 distribution of pediatric vaccines);

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

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

8 (vii) A state health benefits risk pool;

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

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

14 (x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. section
15 2504(e)).

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

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

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

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

26 (m) "Eligible employee" means an employee who works on a full-time basis with a
27 normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the
28 term shall also include an employee who works on a full-time basis with a normal work week of
29 anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this
30 eligibility criterion is applied uniformly among all of the employer's employees and without
31 regard to any health status-related factor. The term includes a self-employed individual, a sole
32 proprietor, a partner of a partnership, and may include an independent contractor, if the self-
33 employed individual, sole proprietor, partner, or independent contractor is included as an
34 employee under a health benefit plan of a small employer, but does not include an employee who

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

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

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

12 (p) "Family composition" means:

- 13 (1) Enrollee;
- 14 (2) Enrollee, spouse and children;
- 15 (3) Enrollee and spouse; or
- 16 (4) Enrollee and children.

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

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

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

30 (2) For purposes of this chapter:

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

1 in the partnership, or to their dependents, as defined under the terms of the plan, fund or program,
2 directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph
3 (ii) of this subdivision, as an employee welfare benefit plan that is a group health plan;

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

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

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

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

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

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

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

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

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

26 (iv) Workers' compensation or similar insurance;

27 (v) Automobile medical payment insurance;

28 (vi) Credit-only insurance;

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

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

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

1 of the plan:

2 (i) Limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (iii) In the case of a policy or certificate that is described in this paragraph and that is

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

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

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

7 (1) Health status;

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

9 (3) Claims experience;

10 (4) Receipt of health care;

11 (5) Medical history;

12 (6) Genetic information;

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

15 (8) Disability.

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

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

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

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

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

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

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

34 (iii) If the individual is employed by an employer which offers multiple health benefit

1 plans and the individual elects a different plan during an open enrollment period;

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

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

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

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

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

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

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

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

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

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

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

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

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

32 (2) "Preexisting condition" does not mean a condition for which medical advice,
33 diagnosis, care, or treatment was recommended or received for the first time while the covered
34 person held creditable coverage and that was a covered benefit under the health benefit plan,

1 provided that the prior creditable coverage was continuous to a date not more than ninety (90)
2 days prior to the enrollment date of the new coverage.

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

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

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

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

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

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

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

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

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

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

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

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

15 (nn) "Affordable health benefit plan" means a health benefit plan that is designed to
16 promote health, i.e. disease prevention, wellness, disease management, preventive care, and/or
17 similar health and wellness programs; that is actively marketed by a carrier in accordance with
18 this chapter; and that may be modified or terminated by a carrier in accordance with section 27-
19 50-6.

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

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

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

25 SECTION 6. Chapter 27-50 of the General Laws entitled "Small Employer Health
26 Insurance Availability Act" is hereby amended by adding thereto the following section:

27 **27-50-17. Affordable health plan reinsurance program for small businesses.** – (a)
28 The commissioner shall allocate funds from the affordable health plan reinsurance fund for the
29 affordable health reinsurance program.

30 (b) The affordable health reinsurance program for small businesses shall only be
31 available to low wage firms, as defined in section 27-50-3, who pay a minimum of fifty percent
32 (50%), as defined in section 27-50-3, of single coverage premiums for their eligible employees,
33 and who purchase the wellness health benefit plan pursuant to section 27-50-10. Eligibility shall
34 be determined based on state and federal corporate tax filings. All eligible employees, as defined

1 in section 27-50-3, employed low wage firms as defined in section 27-50-3-(oo) shall be eligible
2 for the reinsurance program if at least one low wage eligible employee as defined in regulation is
3 enrolled in the employer's wellness health benefit plan.

4 (c) The affordable health plan reinsurance shall be in the form of a carrier cost-sharing
5 arrangement, which encourages carriers to offer a discounted premium rate to participating
6 individuals, and whereby the reinsurance fund subsidizes the carriers' losses within a prescribed
7 corridor of risk as determined by regulation.

8 (d) The specific structure of the reinsurance arrangement shall be defined by regulations
9 promulgated by the commissioner.

10 (e) All carriers who participate in the Rhode Island RItE Care program as defined in
11 section 42-12.3-4 and the procurement process for the Rhode Island state employee account, as
12 described in chapter 36-12, must participate in the affordable health plan reinsurance program.

13 (f) The commissioner shall determine total eligible enrollment under qualifying small
14 group health insurance contracts by dividing the funds available for distribution from the
15 reinsurance fund by the estimated per member annual cost of claims reimbursement from the
16 reinsurance fund.

17 (g) The commissioner shall suspend the enrollment of new employers under qualifying
18 small group health insurance contracts if the director determines that the total enrollment reported
19 under such contracts is projected to exceed the total eligible enrollment, thereby resulting in
20 anticipated annual expenditures from the reinsurance fund in excess of ninety-five percent (95%)
21 of the total funds available for distribution from the fund.

22 (h) In the event the available funds in the affordable health reinsurance fund as created in
23 section 42-14.5-3 are insufficient to satisfy all claims submitted to the fund in any calendar year,
24 those claims in excess of the available funds shall be due and payable in the succeeding calendar
25 year, or when sufficient funds become available whichever shall first occur. Unpaid claims from
26 any prior year shall take precedence over new claims submitted in any one year.

27 (i) The commissioner shall provide the health maintenance organization, health insurers
28 and health plans with notification of any enrollment suspensions as soon as practicable after
29 receipt of all enrollment data. However, the suspension of issuance of qualifying small group
30 health insurance contracts shall not preclude the addition of new employees of an employer
31 already covered under such a contract or new dependents of employees already covered under
32 such contracts.

33 (j) The premiums of qualifying small group health insurance contracts must be no more
34 than ninety percent (90%) of the actuarially-determined and commissioner approved premium for

1 this health plan without the reinsurance program assistance.

2 (k) The commissioner shall prepare periodic public reports in order to facilitate
3 evaluation and ensure orderly operation of the funds, including, but not limited to, an annual
4 report of the affairs and operations of the fund, containing an accounting of the administrative
5 expenses charged to the fund. Such reports shall be delivered to the co-chairs of the joint
6 legislative committee on health care oversight by March 1st of each year.

7 SECTION 7. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The
8 Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended
9 to read as follows:

10 **42-14.5-3. Powers and duties. [Contingent effective date; see notes under section 42-**
11 **14.5-1.] --** The health insurance commissioner shall have the following powers and duties:

12 (a) To conduct an annual public meeting or meetings, separate and distinct from rate
13 hearings pursuant to section 42-62-13, regarding the rates, services and operations of insurers
14 licensed to provide health insurance in the state the effects of such rates, services and operations
15 on consumers, medical care providers and patients, and the market environment in which such
16 insurers operate. Notice of not less than ten (10) days of said hearing(s) shall go to the general
17 assembly, the governor, the Rhode Island medical society, the Hospital Association of Rhode
18 Island, the director of health, and the attorney general. Public notice shall be posted on the
19 department's web site and given in the newspaper of general circulation, and to any entity in
20 writing requesting notice.

21 (b) To make recommendations to the governor and the joint legislative committee on
22 health care oversight regarding health care insurance and the regulations, rates, services,
23 administrative expenses, reserve requirements, and operations of insurers providing health
24 insurance in the state, and to prepare or comment on, upon the request of the co-chairs of the joint
25 committee on health care oversight or upon the request of the governor, draft legislation to
26 improve the regulation of health insurance. In making such recommendations, the commissioner
27 shall recognize that it is the intent of the legislature that the maximum disclosure be provided
28 regarding the reasonableness of individual administrative expenditures as well as total
29 administrative costs. The commissioner shall also make recommendations on the levels of
30 reserves including consideration of: targeted reserve levels; trends in the increase or decrease of
31 reserve levels; and insurer plans for distributing excess reserves.

32 (c) To establish a consumer/business/labor/medical advisory council to obtain
33 information and present concerns of consumers, business and medical providers affected by
34 health insurance decisions. The council shall be involved in the planning and conduct of the

1 public meeting in accordance with subsection (a) above. The advisory council shall assist in the
2 design of an insurance complaint process to ensure that small businesses whom experience
3 extraordinary rate increases in a given year could request and receive a formal review by the
4 department. The advisory council shall assess views of the health provider community relative to
5 insurance rates of reimbursement, billing and reimbursement procedures, and the insurers' role in
6 promoting efficient and high quality health care. The advisory council shall issue an annual report
7 of findings and recommendations to the governor and the joint legislative committee on health
8 care oversight. The advisory council is to be diverse in interests and shall include representatives
9 of community consumer organizations; small businesses, other than those involved in the sale of
10 insurance products; and hospital, medical, and other health provider organizations. Such
11 representatives shall be nominated by their respective organizations. The advisory council shall
12 be co-chaired by the health insurance commissioner and a community consumer organization or
13 small business member to be elected by the full advisory council.

14 (d) To establish and provide guidance and assistance to a subcommittee ("The
15 Professional Provider-Health Plan Work Group") of the advisory council created pursuant to
16 subsection (c) above, composed of health care providers and Rhode Island licensed health plans.
17 This subcommittee shall develop a plan to implement the following activities:

18 (i) By January 1, 2006, a method whereby health plans shall disclose to contracted
19 providers the fee schedules used to provide payment to those providers for services rendered to
20 covered patients;

21 (ii) By April 1, 2006, a standardized provider application and credentials verification
22 process, for the purpose of verifying professional qualifications of participating health care
23 providers;

24 (iii) By September 1, 2006, a uniform health plan claim form to be utilized by
25 participating providers;

26 (iv) By December 1, 2006, contractual disclosure to participating providers of the
27 mechanisms for resolving health plan/provider disputes; and

28 (v) By February 1, 2007, a uniform process for confirming in real time patient insurance
29 enrollment status, benefits coverage, including co-pays and deductibles.

30 A report on the work of the subcommittee shall be submitted by the health insurance
31 commissioner to the joint legislative committee on health care oversight on March 1, 2006 and
32 March 1, 2007.

33 (e) To enforce the provisions of Title 27 and Title 42 as set forth in section 42-14-5(d).

34 [\(f\) There is hereby established the Rhode Island Affordable Health Plan Reinsurance](#)

1 [Fund. The fund shall be used to effectuate the provisions of sections 27-18.5-8 and 27-50-17.](#)

2 SECTION 8. This act shall take effect on July 1, 2007 and shall also be subject to and
3 conditioned upon: (i) the creation and funding by the general assembly of an Affordable Health
4 Plan Reinsurance Fund; and (ii) certification by the commissioner or the commissioner's designee
5 that there exists adequate and appropriate sums available in the fund to fulfill the objectives of
6 this act.

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LC00762/SUB A/3
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE -- THE RHODE ISLAND HEALTHCARE AFFORDABILITY
ACT OF 2006 - PART VII - SMALL BUSINESSES

1 This act would amend the affordable health plan reinsurance program for small
2 businesses as part of the Rhode Island health care affordability act.

3 This act would take effect on July 1, 2007 and would also be subject to and conditioned
4 upon: (i) the creation and funding by the general assembly of an Affordable Health Plan
5 Reinsurance Fund; and (ii) certification by the commissioner or the commissioner's designee that
6 there exists adequate and appropriate sums available in the fund to fulfill the objectives of this
7 act.

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A N A C T

RELATING TO INSURANCE -- THE RHODE ISLAND HEALTHCARE AFFORDABILITY ACT OF
2006 - PART VII - SMALL BUSINESSES

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LC00762/SUB A/3
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Presented by