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

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2006

A N A C T

RELATING TO MEDICAL INSURANCE

Introduced By: Senator William A. Walaska

Date Introduced: February 09, 2006

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Sections 27-50-3 and 27-50-5 of the General Laws in Chapter 27-50
2 entitled "Small Employer Health Insurance Availability Act" are hereby amended to read as
3 follows:

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

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

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

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

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

1 state, an association which:

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

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

4 insurance;

5 (3) Does not condition membership in the association on any health-status related factor

6 relating to an individual (including an employee of an employer or a dependent of an employee);

7 (4) Makes health insurance coverage offered through the association available to all

8 members regardless of any health status-related factor relating to those members (or individuals

9 eligible for coverage through a member);

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

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

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

13 (7) Has a constitution and bylaws; and

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

15 (f) "Carrier" or "small employer carrier" means all entities licensed, or required to be

16 licensed, in this state that offer health benefit plans covering eligible employees of one or more

17 small employers pursuant to this chapter. For the purposes of this chapter, carrier includes an

18 insurance company, a nonprofit hospital or medical service corporation, a fraternal benefit

19 society, a health maintenance organization as defined in chapter 41 of this title or as defined in

20 chapter 62 of title 42, or any other entity providing a plan of health insurance or health benefits

21 subject to state insurance regulation.

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.
21 (k) "Director" means the director of the department of business regulation.
22 (l) "Economy health plan" means a lower cost health benefit plan developed pursuant to
23 the provisions of section 27-50-10.
24 (m) "Eligible employee" means an employee who works on a full-time basis with a
25 normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the
26 term shall also include an employee who works on a full-time basis with a normal work week of
27 anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this
28 eligibility criterion is applied uniformly among all of the employer's employees and without
29 regard to any health status-related factor. The term includes a self-employed individual, a sole
30 proprietor, a partner of a partnership, and may include an independent contractor, if the self-
31 employed individual, sole proprietor, partner, or independent contractor is included as an
32 employee under a health benefit plan of a small employer, but does not include an employee who
33 works on a temporary or substitute basis or who works less than seventeen and one-half (17.5)
34 hours per week. Any retiree under contract with any independently incorporated fire district is

1 also included in the definition of eligible employee. Persons covered under a health benefit plan
2 pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered
3 "eligible employees" for purposes of minimum participation requirements pursuant to section 27-
4 50-7(d)(9).

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

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

10 (p) "Family composition" means:

11 (1) Enrollee;

12 (2) Enrollee, spouse and children;

13 (3) Enrollee and spouse; or

14 (4) Enrollee and children.

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

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

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

28 (2) For purposes of this chapter:

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

1 (ii) of this subdivision, as an employee welfare benefit plan that is a group health plan;

2 (ii) In the case of a group health plan, the term "employer" also includes the partnership 3 in relation to any partner; and

4 (iii) In the case of a group health plan, the term "participant" also includes an individual 5 who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary 6 who is, or may become, eligible to receive a benefit under the plan, if:

7 (A) In connection with a group health plan maintained by a partnership, the individual is 8 a partner in relation to the partnership; or

9 (B) In connection with a group health plan maintained by a self-employed individual, 10 under which one or more employees are participants, the individual is the self-employed 11 individual.

12 (t) (1) "Health benefit plan" means any hospital or medical policy or certificate, major 13 medical expense insurance, hospital or medical service corporation subscriber contract, or health 14 maintenance organization subscriber contract. Health benefit plan includes short-term and 15 catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as 16 otherwise specifically exempted in this definition.

17 (2) "Health benefit plan" does not include one or more, or any combination of, the 18 following:

19 (i) Coverage only for accident or disability income insurance, or any combination of 20 those;

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

22 (iii) Liability insurance, including general liability insurance and automobile liability 23 insurance;

24 (iv) Workers' compensation or similar insurance;

25 (v) Automobile medical payment insurance;

26 (vi) Credit-only insurance;

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

28 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant 29 to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other 30 insurance benefits.

31 (3) "Health benefit plan" does not include the following benefits if they are provided 32 under a separate policy, certificate, or contract of insurance or are otherwise not an integral part 33 of the plan:

34 (i) Limited scope dental or vision benefits;

1 (ii) Benefits for long-term care, nursing home care, home health care, community-based
2 care, or any combination of those; or
3 (iii) Other similar, limited benefits specified in federal regulations issued pursuant to
4 Pub. L. No. 104-191.
5 (4) "Health benefit plan" does not include the following benefits if the benefits are
6 provided under a separate policy, certificate or contract of insurance, there is no coordination
7 between the provision of the benefits and any exclusion of benefits under any group health plan
8 maintained by the same plan sponsor, and the benefits are paid with respect to an event without
9 regard to whether benefits are provided with respect to such an event under any group health plan
10 maintained by the same plan sponsor:
11 (i) Coverage only for a specified disease or illness; or
12 (ii) Hospital indemnity or other fixed indemnity insurance.
13 (5) "Health benefit plan" does not include the following if offered as a separate policy,
14 certificate, or contract of insurance:
15 (i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the
16 Social Security Act, 42 U.S.C. section 1395ss(g)(1);
17 (ii) Coverage supplemental to the coverage provided under 10 U.S.C. section 1071 et
18 seq.; or
19 (iii) Similar supplemental coverage provided to coverage under a group health plan.
20 (6) A carrier offering policies or certificates of specified disease, hospital confinement
21 indemnity, or limited benefit health insurance shall comply with the following:
22 (i) The carrier files on or before March 1 of each year a certification with the director
23 that contains the statement and information described in paragraph (ii) of this subdivision;
24 (ii) The certification required in paragraph (i) of this subdivision shall contain the
25 following:
26 (A) A statement from the carrier certifying that policies or certificates described in this
27 paragraph are being offered and marketed as supplemental health insurance and not as a substitute
28 for hospital or medical expense insurance or major medical expense insurance; and
29 (B) A summary description of each policy or certificate described in this paragraph,
30 including the average annual premium rates (or range of premium rates in cases where premiums
31 vary by age or other factors) charged for those policies and certificates in this state; and
32 (iii) In the case of a policy or certificate that is described in this paragraph and that is
33 offered for the first time in this state on or after July 13, 2000, the carrier shall file with the
34 director the information and statement required in paragraph (ii) of this subdivision at least thirty

1 (30) days prior to the date the policy or certificate is issued or delivered in this state.

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

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

5 (1) Health status;

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

7 (3) Claims experience;

8 (4) Receipt of health care;

9 (5) Medical history;

10 (6) Genetic information;

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

13 (8) Disability.

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

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

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

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

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

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

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

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

34 (iv) If a court has ordered coverage be provided for a spouse or minor or dependent child

1 under a covered employee's health benefit plan and a request for enrollment is made within thirty
2 (30) days after issuance of the court order;
3 (v) If the individual changes status from not being an eligible employee to becoming an
4 eligible employee and requests enrollment within thirty (30) days after the change in status;
5 (vi) If the individual had coverage under a COBRA continuation provision and the
6 coverage under that provision has been exhausted; or
7 (vii) Who meets the requirements for special enrollment pursuant to section 27-50-7 or
8 27-50-8.
9 (x) "Limited benefit health insurance" means that form of coverage that pays stated
10 predetermined amounts for specific services or treatments or pays a stated predetermined amount
11 per day or confinement for one or more named conditions, named diseases or accidental injury.
12 (y) "Medical care" means amounts paid for:
13 (1) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid
14 for the purpose of affecting any structure or function of the body;
15 (2) Transportation primarily for and essential to medical care referred to in subdivision
16 (1); and
17 (3) Insurance covering medical care referred to in subdivisions (1) and (2) of this
18 subsection.
19 (z) "Network plan" means a health benefit plan issued by a carrier under which the
20 financing and delivery of medical care, including items and services paid for as medical care, are
21 provided, in whole or in part, through a defined set of providers under contract with the carrier.
22 (aa) "Person" means an individual, a corporation, a partnership, an association, a joint
23 venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any
24 combination of the foregoing.
25 (bb) "Plan sponsor" has the meaning given this term under section 3(16)(B) of the
26 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(16)(B).
27 (cc) (1) "Preexisting condition" means a condition, regardless of the cause of the
28 condition, for which medical advice, diagnosis, care, or treatment was recommended or received
29 during the six (6) months immediately preceding the enrollment date of the coverage.
30 (2) "Preexisting condition" does not mean a condition for which medical advice,
31 diagnosis, care, or treatment was recommended or received for the first time while the covered
32 person held creditable coverage and that was a covered benefit under the health benefit plan,
33 provided that the prior creditable coverage was continuous to a date not more than ninety (90)
34 days prior to the enrollment date of the new coverage.

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

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

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

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

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

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

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

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

(kk) "Small employer" means, except for its use in section 27-50-7, any person, firm, corporation, partnership, association, political subdivision, or self-employed individual that is actively engaged in business including, but not limited to, a business or a corporation organized under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of another state that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no fewer than two (2) and no more than fifty (50) eligible employees, with a normal work week of thirty (30) or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered one employer. Subsequent to the

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

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

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

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

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

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

(i) Age;

(ii) Gender; and

(iii) Family composition.

(2) (A) A small employer carrier who as of June 1, 2000, varied rates by health status may vary the adjusted community rates for health status by ~~ten~~ twenty-five percent ~~(10%)~~ (25%), provided that the resulting rates comply with the other requirements of this section, including subdivision (5) of this subsection.

(B) Small employer carriers are permitted to develop separate adjusted community rates for small employers with two (2) to ten (10) eligible employees, eleven (11) to twenty-five (25) eligible employees, and twenty-six (26) to fifty (50) eligible employees. The requirements of section 27-50-5, including, but not limited to subdivisions (4) and (5) of this subsection and subsections (d), (f), and (h), shall apply separately to each rating classification.

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

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

(5) For each health benefit plan offered by a carrier, the highest premium rate for each family composition type shall not exceed ~~four (4)~~ six (6) times the premium rate that could be charged to a small employer with the lowest premium rate for that family composition.

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

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

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

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

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

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

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

The calculation of premium discounts, rebates, or modifications to otherwise applicable copayments or deductibles for affordable health benefit plans shall be made in a manner consistent with accepted actuarial standards and based on actual or reasonably anticipated small employer claims experience. As used in the preceding sentence, "accepted actuarial standards" includes actuarially appropriate use of relevant data from outside the claims experience of small

1 employers covered by affordable health plans, including, but not limited to, experience derived
2 from the large group market, as this term is defined in section 27-18.6-2(20).
3 (e) For the purposes of this section, a health benefit plan that contains a restricted
4 network provision shall not be considered similar coverage to a health benefit plan that does not
5 contain such a provision, provided that the restriction of benefits to network providers results in
6 substantial differences in claim costs.
7 (f) The director may establish regulations to implement the provisions of this section and
8 to assure that rating practices used by small employer carriers are consistent with the purposes of
9 this chapter, including regulations that assure that differences in rates charged for health benefit
10 plans by small employer carriers are reasonable and reflect objective differences in plan design or
11 coverage (not including differences due to the nature of the groups assumed to select particular
12 health benefit plans or separate claim experience for individual health benefit plans).
13 (g) In connection with the offering for sale of any health benefit plan to a small
14 employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation
15 and sales materials, of all of the following:
16 (1) The provisions of the health benefit plan concerning the small employer carrier's
17 right to change premium rates and the factors, other than claim experience, that affect changes in
18 premium rates;
19 (2) The provisions relating to renewability of policies and contracts;
20 (3) The provisions relating to any preexisting condition provision; and
21 (4) A listing of and descriptive information, including benefits and premiums, about all
22 benefit plans for which the small employer is qualified.
23 (h) (1) Each small employer carrier shall maintain at its principal place of business a
24 complete and detailed description of its rating practices and renewal underwriting practices,
25 including information and documentation that demonstrate that its rating methods and practices
26 are based upon commonly accepted actuarial assumptions and are in accordance with sound
27 actuarial principles.
28 (2) Each small employer carrier shall file with the director annually on or before March
29 15 an actuarial certification certifying that the carrier is in compliance with this chapter and that
30 the rating methods of the small employer carrier are actuarially sound. The certification shall be
31 in a form and manner, and shall contain the information, specified by the director. A copy of the
32 certification shall be retained by the small employer carrier at its principal place of business.
33 (3) A small employer carrier shall make the information and documentation described in
34 subdivision (1) of this subsection available to the director upon request. Except in cases of

1 violations of this chapter, the information shall be considered proprietary and trade secret

2 information and shall not be subject to disclosure by the director to persons outside of the

3 department except as agreed to by the small employer carrier or as ordered by a court of

4 competent jurisdiction.

5 (i) The requirements of this section apply to all health benefit plans issued or renewed on

6 or after October 1, 2000.

7 SECTION 2. This act shall take effect on January 1, 2007.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N   A C T

RELATING TO MEDICAL INSURANCE

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1 This act would attempt to address affordability concerns of small employers by
2 permitting premium rates to vary based on group size and up to 25% based on health status, and
3 by limiting group rates to employers with at least 2 employees.
4 This act would be effective January 1, 2007.

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