



Description of graphic: RI State Seal an anchor in gold behind a blue wheelchair logo. Just below is a blue banner with the state motto "Hope". All are in the center of a ring of 8 blue stars, in groups of 2 separated by the logos for Braille, hearing aids, low vision and amplified phone.

Governor's Commission on Disabilities Legislation Committee

Monday April 9, 2012 3-4:30 PM

John O. Pastore Center, 41 Cherry Dale Court,
Cranston, RI 02920-3049

(voice) 401-462-0100 (fax) 462-0106 (tty) via RI Relay 711

(e-mail) disabilities@gcd.ri.gov

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 meeting graphic	<p>Attendees: Linda Ward (Chair.); William R. Inlow (Vice Chair.); Sharon Brinkworth; Rosemary C. Carmody; Julie DeRosa; Arthur M. Plitt; Gwendolyn Reeve; & Angelina Stabile</p> <p>Absentees: Heather Daglieri; Linda Deschenes; Sarah Everhart Skeels; Timothy Flynn; Elaina Goldstein; Roger Harris; Kathleen Heren; Kate McCarthy-Barnett; Paula Parker; Theresa Thoelke; Msgr. Gerard O. Sabourin; & Dawn Wardyga</p>
<p>Guests:</p>	
<p>Staff:</p>	<p>Bob Cooper & Jessica Burrows</p>

	Agenda Topics	Moderator/Leader	Time
 Clock graphic	<p>Call to Order and Acceptance of the Minutes</p> <p>Chair calls the meeting to order at 3:05 PM Introductions of Commissioners and guests</p>	<p>Linda Ward, Chairperson</p>	<p>3:00</p>
<p>MOTION: To accept the minutes of the previous meeting as presented AS/SB passed unanimously</p>			

Action Items:			
 law graphic	<p>Commission's Legislative Package</p>	<p>Bob Cooper, Executive Secretary</p>	<p>4:15</p>
<p>Purpose/Goal: To update the Committee on the status of bills and decide which need amending.</p> <hr/> <p>Discussion: Status Report as of Friday April 6, 2012</p> <hr/> <p>S 2652 & H 7838 ACTS RELATING TO PUBLIC RECORDS - ACCESS TO PUBLIC RECORDS by Sen. Sheehan & Rep. Lally, at the request of the Attorney General & H 7555 by Rep. Marcello at the request of Common Cause.</p> <p>These acts would make various amendments to the access to public records act, including: making public all records which are identifiable to an individual applicant for benefits, client, patient, student, or employee, including, but not limited to, personnel, medical treatment, welfare, employment security, pupil records, all records relating to a client/attorney relationship and to a doctor/patient relationship, including and all personal or medical information relating to an individual in any files, including information relating to medical or psychological facts, personal finances, welfare, employment security, student performance,</p>			

	Agenda Topics	Moderator/Leader	Time
	<p>or information in personnel files unless individually-identifiable records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy. The Legislation Committee found them harmful. POTENTIAL AMENDMENTS:</p>		

Current Text

- 2-27 For the purposes of this chapter, the following records shall not be deemed public:
- 2-28 (A)(I)(a) All records ~~which are identifiable to an individual applicant for benefits, client,~~
- 2-29 ~~patient, student, or employee, including, but not limited to, personnel, medical treatment, welfare,~~
- 2-30 ~~employment security, pupil records, all records relating to a client/attorney relationship and to a~~
- 2-31 ~~doctor/patient relationship, including and all personal or medical information relating to an~~
- 2-32 ~~individual in any files, including information relating to medical or psychological facts, personal~~
- 2-33 ~~finances, welfare, employment security, student performance, or information in personnel files~~
- 2-34 ~~maintained to hire, evaluate, promote, or discipline any employee of a public body;~~

Alternative Text

- 2-28 (A)(I)(a) All records which are identifiable to an individual applicant for benefits, client,
- 2-29 patient, student, ~~or employee,~~ including, but not limited to, ~~personnel,~~ medical treatment, welfare,
- 2-30 employment security, pupil records, all records relating to a client/attorney relationship and to a
- 2-31 doctor/patient relationship, including and all personal or medical information relating to an
- 2-32 individual in any files, ~~including information relating to medical or psychological facts, personal~~
- 2-33 ~~finances, welfare, employment security, student performance, or information in personnel files~~
- 2-34 ~~maintained to hire, evaluate, promote, or discipline any employee of a public body;~~

2nd change adding to 38-2-9. Jurisdiction of superior court a new subsection between lines 8-29 & 8-30
[\(e\) The court shall impose a civil fine not exceeding one thousand dollars \(\\$1,000\) against a public body or official found to have committed a knowing and willful disclosure of personal individually-identifiable records which would constitute a clearly unwarranted invasion of personal privacy pursuant to 5 U.S.C. 552 \(b\)\(6\).](#)



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MOTION: To recommend S 2652 & H 7838 ACTS RELATING TO PUBLIC RECORDS - ACCESS TO PUBLIC RECORDS be amended as revised to include clergy counseling AP/GR passed, Nay WI

H 7806 AN ACT RELATING TO STATE AFFAIRS AND GOVERNMENT by Rep. Naughton at the request of the Attorney General

This act would create a new chapter entitled “Criminal Background Check Act” that would provide for national background checks for all persons applying to be direct patient access employees in a long-term care facility or provider, including, but not limited to, those facilities licensed under chapters 23-17, 23-17.4, 23-17.7.1 and 40.1-24.

This act would take effect on January 1, 2013.

Current Text 1.

- 4-33 (1) The following offenses are considered level one offenses: Murder, manslaughter, first
- 4-34 degree sexual assault, second degree sexual assault, assault on persons sixty (60) years of age or
- 5-1 older, assault with intent to commit specified felonies (murder, robbery, rape, burglary, or the
- 5-2 abominable and detestable crime against nature), felony assault, patient abuse, neglect or
- 5-3 mistreatment of patients, burglary, first degree arson, robbery, any felony involving the illegal
- 5-4 manufacture, sale or delivery of a controlled substance or possession with intent to manufacture,
- 5-5 a controlled substance, felony obtaining money under false pretenses, felony
- 5-6 embezzlement, abuse, neglect and/or exploitation of adults with severe impairments, exploitation
- 5-7 of elders, felony larceny, or felony banking law violations, or a crime under section 1128(a) of
- 5-8 the Social Security Act (42 U.S.C. 1320a-7(a)).
- 5-9 (2) The following offenses are considered level two offenses: Felony drug possession, and
- 5-10 third degree sexual assault.

Alternative Text 1.

4-33 (1) The following offenses are considered level one offenses: Murder, manslaughter, first
4-34 degree sexual assault, second degree sexual assault, assault on persons sixty (60) years of age or
5-1 older, assault with intent to commit specified felonies (murder, robbery, rape, burglary, or the
5-2 abominable and detestable crime against nature), felony assault, patient abuse, neglect or
5-3 mistreatment of patients, first degree arson, robbery, any felony involving the illegal
5-4 manufacture, or possession with intent to manufacture,
5-5 a controlled substance, felony obtaining money under false pretenses, felony
5-6 embezzlement, abuse, neglect and/or exploitation of adults with severe impairments, exploitation
5-7 of elders, felony larceny, or felony banking law violations, or a crime under section 1128(a) of
5-8 the Social Security Act (42 U.S.C. 1320a-7(a)).

5-9 (2) The following offenses are considered level two offenses: Felony drug possession, involving sale or
delivery of a controlled substance, or possession with intent to sell or deliver a controlled substance;
5-10 burglary, and third degree sexual assault.

Current Text 2.

6-7 (1) The applicant must submit the request for appeal in writing to the EOHHS within
6-8 fourteen (14) days of the applicant's receipt of the disqualification notice provided in subsection
6-9 42-9.4-2(d). In the request, the applicant must include a copy of his or her disqualification notice
6-10 that identifies the specific disqualifying offense and provide evidence that supports the factors in
6-11 subsection (c).

6-12 (2) Within thirty (30) days of receipt of the applicant's request, the EOHHS shall review
6-13 the applicant's submitted materials and conduct a hearing for the applicant to demonstrate that the
6-14 disqualification should be overturned due to any or some combination of the factors in subsection
6-15 (c).

6-16 (3) Upon consideration of the factors in subsection (c), if EOHHS determines that the
6-17 applicant's disqualification should not be overturned or the applicant failed to submit a timely
6-18 request for appeal, the EOHHS must deny the appeal. Upon denial, the EOHHS shall notify, in
6-19 writing, the applicant, the covered facility, and the department that the disqualification was not
6-20 overturned and the basis for the denial.

6-21 (4) The EOHHS shall grant the appeal if it finds that the information contained in the
6-22 applicant's criminal background check and applicant's presentation of pertinent factors in
6-23 subsection (c) warrant that the applicant's disqualification should be overturned. If an applicant's
6-24 disqualification is overturned, the EOHHS shall notify the applicant, the covered facility, and the
6-25 department of the decision in writing and state the specific findings thereto.

Alternative Text 2.

6-7 An applicant or employee against whom disqualifying information is based on a level two offense has
been found may request that a copy of the criminal background report be sent to the employer who
shall make a judgment regarding the continued employment of the employee.



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MOTION: To recommend H 7806 AN ACT RELATING TO STATE AFFAIRS
AND GOVERNMENT be amended as proposed above AS/AP passed, RC
Abstained.

12 H 7616 AN ACT RELATING TO LABOR AND LABOR RELATIONS - RE-EMPLOYMENT
OF WORKERS WHO BECOME DISABLED by Rep. Ehrhardt Requested by the Governor's
Commission on Disabilities

This act would specify that a government employee must be unable to carry out their job
duties with or without reasonable accommodation to be transferred or asked to retire. The
employee can ask to be placed on a "reemployment list" which will be the primary means
used to fill vacancies that are comparable to the position they originally held. It also would
amend the definition of an employee to include active service an on leave of absence due to
injury.

This act would take effect January 1, 2013

2 CREATING A SPECIAL LEGISLATIVE COMMISSION TO STUDY THE RE-EMPLOYMENT OF STATE
3 AND LOCAL GOVERNMENT WORKERS WHO BECOME DISABLED
4

5 RESOLVED, That a special legislative commission be and the same is hereby created consisting of 22
6 members:

7 three (3) of whom shall be members of the Senate, not more than two (2) from the same political party, to
8 be appointed by the Senate President;

9 three (3) of whom shall be members of the House, not more than two (2) from the same political party, to
10 be appointed by the Speaker;

11 one of whom shall be state or municipal beneficiaries of the disability retirement program, one of whom
12 shall be appointed by the Senate President;

13 one of whom shall be an attorney practicing before the Workers' Compensation Court one of whom shall
14 be appointed by the Speaker;

15 one of whom shall be the Administrator of the State Division of Human Resources, or designee;

16 one of whom shall be the Administrator of the State Division of Workers' Compensation, or designee;

17 one of whom shall be the Administrator of the State Employees Workers' Compensation unit, or designee;

18 one of whom shall be the Administrator of the State Office of Rehabilitation Services, or designee;

19 one of whom shall be the Chairperson of the Governor's Commission on Disabilities, or designee;

20 one of whom shall be the Chairperson of the Governor's Workforce Board, or designee;

21 one of whom shall be the Chairperson of the Retirement Board of the Employees' Retirement System of
22 Rhode Island, or designee;

23 Chapter A one of whom shall be the President of American Federation of State, County and Municipal
24 Employees Rhode Island Retirees Chapter 94, or designee;

25 one of whom shall be the President of Council 94 of the American Federation of State, County and
26 Municipal Employees;

27 one of whom shall be the President of Rhode Island American Federation of Labor - Congress of Industrial
28 Organizations, or designee;

29 one of whom shall be the President of Rhode Island Lodge Fraternal Order of Police or designee;

30 one of whom shall be the President of Rhode Island State Association of Fire Fighters or designee;

31 one of whom shall be the President of the RI League of Cities and Towns, or designee; and

32 one of whom shall be the President Rhode Island Federation of Teachers and Health Professionals or
33 designee.

34 In lieu of any appointment of a member of the legislature to a permanent advisory commission, a
35 legislative study commission, or any commission created by a General Assembly resolution, the appointing
36 authority may appoint a member of the general public to serve in lieu of a legislator, provided that the
37 Majority Leader or the Minority Leader of the political party which is entitled to the appointment, consents
38 to the member of the general public.

39 The purpose of said commission shall be to study refocusing the state and municipal disability pension
40 systems into reemployment systems and to provide a comprehensive report with recommendations to the
41 General Assembly.

42 Forthwith upon passage of this resolution, the members of the commission shall meet on or before August
43 2012, and shall select co-chairpersons from among the legislators.

44 Twelve (12) members shall constitute a quorum for purposes of approving recommendations and/or the
45 commission report or other action items.

46 Vacancies in said commission shall be filled in like manner as the original appointment.

47 The membership of said commission shall receive no compensation for their services.

48 All departments and agencies of the state shall furnish such advice and information, documentary and
49 otherwise, to said commission and its agents as is deemed necessary or desirable by the commission to
50 facilitate the purposes of this resolution.

51 The Joint Committee on Legislative Services is hereby authorized and directed to provide suitable quarters
52 for said commission; and be it further

53 RESOLVED, That the commission shall report its findings and recommendations to the General Assembly
54 no later than January 30, 2013, and said commission shall expire on January 30, 2014.



Potential MOTION: To recommend 12 H 7616 AN ACT RELATING TO LABOR

**AND LABOR RELATIONS - RE-EMPLOYMENT OF WORKERS WHO
BECOME DISABLED** be amended *as proposed above BI/JD passed GR*
Abstained

Status of the Commission's Legislative Package, as of April 6, 2012.

Commission Supports
Scheduled for hearing and/or consideration

Senate Finance Committee

Next Action on: 4 /11/1012 @ 2 PM, in room 211

12 S2203 AN ACT RELATING TO STATE AFFAIRS AND GOVERNMENT -- RHODE ISLAND HOUSING RESOURCES ACT OF 1998

Sen. Tassoni

Identical to H 7265 & 7237

Senate letter send 2/14/2012

House Health, Education, & Welfare Committee

Next Action on: 4 /11/2012 @ Rise, in Room 135

12 H7739 AN ACT RELATING TO EDUCATION -- CHILDREN WITH DISABILITIES

Rep. McNamara

Requested by the Governor's Commission on Disabilities

Identical to S 2446

House letter send 2/21/2012

12 H7928 AN ACT RELATING TO HUMAN SERVICES - SERVICES FOR ADULTS WITH AUTISM SPECTRUM DISORDERS

Rep. Palumbo

Requested by the Governor's Commission on Disabilities

House letter send 3/8 /2012

House Environmental and Natural Resources

Next Action on: 4 /12/2012 @ Rise, in Lounge

12 H7802 AN ACT RELATING TO HEALTH AND SAFETY -- PESTICIDE CONTROL

Rep. Handy

Requested by the Governor's Commission on Disabilities

Identical to S 2443

House letter send 3/5 /2012 Testified on: 3/12/2012 Testified: Bob Cooper

House Finance Committee

Next Action on: 5 /1 /2012 @ 1 PM in Room 35

12 H7265 AN ACT RELATING TO STATE AFFAIRS AND GOVERNMENT -- RHODE ISLAND HOUSING RESOURCES ACT OF 1998

Rep. Slater

Identical to S 2203 & H 7237

House letter send 2/14/2012

Referred to Committee

House Finance Committee

12 H7237 AN ACT RELATING TO STATE AFFAIRS AND GOVERNMENT -- RHODE ISLAND HOUSING RESOURCES ACT OF 1998

Rep. Ucci

Identical to H 7265 & S 2203

House letter send 2/14/2012

12 H7581 AN ACT RELATING TO PUBLIC UTILITIES AND CARRIERS -- PUBLIC TRANSIT INVESTMENT

Rep. O'Grady

House letter send 3/5 /2012

House Judiciary Committee

12 H7839 AN ACT RELATING TO CRIMINAL OFFENSES -- ASSAULTS

Rep. Naughton

Requested by the Governor's Commission on

Similar to S 2730

House letter send 3/8/2012

Senate Environment and Agriculture Committee

12 S2443 AN ACT RELATING TO HEALTH AND SAFETY -- PESTICIDE CONTROL

Sen. Jabour

Requested by the Governor's Commission on

Identical to H 7802

Senate letter send 2/21/2012

Held for Further Study, Continued, or Heard

House Corporations Committee

12 H7573 AN ACT RELATING TO INSURANCE - PRESCRIPTION DRUG BENEFITS

Rep. Keable

Similar to S 2360, S 2428, S

House letter send 2/21/2012 Testified on: 3/7/2012 Testified: Christine Rancourt-Bruzzi

House Finance Committee

12 H7323 AN ARTICLE RELATING TO MAKING APPROPRIATIONS FOR THE SUPPORT OF THE STATE FOR THE FISCAL YEAR ENDING JUNE 30, 2013 - Governor's Commission on Disabilities

Rep. Melo Requested by the Governor
Testified on: 3/21/2012 Testified: Tim Flynn & Bob
12 H7323 AN ARTICLE RELATING TO MAKING APPROPRIATIONS FOR THE SUPPORT OF THE STATE FOR THE FISCAL YEAR ENDING JUNE 30, 2013 - RI Public Transit Authority

Rep. Melo Requested by the Governor
House Testified on: 3/27/2012 Testified: Anglie Stabile
Senate Testified on: Testified: Anglie Stabile
12 H7323 AN ARTICLE RELATING TO MAKING REVISED APPROPRIATIONS IN SUPPORT OF FY 2012 - Governor's Commission on Disabilities

Rep. Melo Requested by the Governor
House Testified on: 3/21/2012 Testified: Tim Flynn & Bob
House Health, Education, & Welfare Committee
12 H7650 AN ACT RELATING TO HUMAN SERVICES - MEDICAL ASSISTANCE

Rep. Corvese Requested by the Governor's Commission on
House letter send 2/21/2012 Testified on: 3/14/2012 Testified: Bob Cooper
House Labor Committee
12 H7616 AN ACT RELATING TO LABOR AND LABOR RELATIONS - RE-EMPLOYMENT OF WORKERS WHO BECAME DISABLED

Rep. Ehrhardt Requested by the Governor's Commission on
House letter send 2/21/2012 Testified on: 3/1/2012 Testified: Tim Flynn & Judi Drew
Senate Judiciary Committee
12 S2730 AN ACT RELATING TO CRIMINAL OFFENSES -- ASSAULTS

Sen. McCaffrey Requested by the Governor's Commission on Similar to H 7839
Senate letter send 3/8/2012 Testified on: 3/29/2012 Testified: Bob Cooper
House Small Business Committee
12 H7628 AN ACT RELATING TO PUBLIC PROPERTY AND WORKS - SMALL DISABILITY BUSINESS ENTERPRISES

Rep. Walsh Requested by the Governor's Commission on Identical to S 2605
House letter send 2/21/2012 Testified on: 2/29/2012 Testified: Bob Cooper
Passed and Referred to
House Health, Education, & Welfare Committee
12 S2446 AN ACT RELATING TO EDUCATION -- CHILDREN WITH DISABILITIES

Sen. Gallo Requested by the Governor's Commission on Identical to H 7739
House letter send 4/4/2012
Senate letter send 2/16/2012 Testified on: 3/7/2012 Testified: Bob Cooper
House Small Business Committee
12 S2605 AN ACT RELATING TO PUBLIC PROPERTY AND WORKS - SMALL DISABILITY BUSINESS ENTERPRISES

Sen. Gallo Requested by the Governor's Commission on Identical to H 7628
House letter send 4/5/2012
Senate letter send 3/5/2012 Testified on: 3/27/2012 Testified: Bob Cooper
**Commission Supports if amended
Held for Further Study, Continued, or Heard**
House Finance Committee
12 H7323 AN ARTICLE RELATING TO CAPITAL DEVELOPMENT PROGRAM

Rep. Melo Requested by the Governor
House letter send 2/14/2012 Testified on: 3/20/2012 Testified: Bob Cooper
Senate Testified on: 3/1/2012 Testified: Bob Cooper
12 H7323 AN ARTICLE RELATING TO HOSPITAL UNCOMPENSATED CARE

Rep. Melo Requested by the Governor
House letter send 2/14/2012
12 H7323 AN ARTICLE RELATING POLICE OFFICERS AND FIREFIGHTERS RELIEF

Rep. Melo Requested by the Governor
House letter send 2/14/2012
12 H 7323 AN ARTICLE RELATING TO RHODE ISLAND VETERANS' HOME

Rep. Melo Requested by the Governor
House letter send 2/14/2012 Testified on: 3/20/2012 Testified: Bob Cooper
Senate Testified on: 2/29/2012 Testified: Bob Cooper
**Commission Opposes
Held for Further Study, Continued, or Heard**
House Finance Committee

12 H7323 AN ARTICLE RELATING TO MEDICAL ASSISTANCE - DENTAL BENEFITS

Rep. Melo Requested by the Governor

House letter send 2/14/2012 Testified on: 2/28/2012 Testified: Bob Cooper

Senate Testified on: 2/7/2012 Testified: Bob Cooper

12 H7323 AN ARTICLE RELATING TO OFFICE OF HEALTH AND HUMAN SERVICES

Rep. Melo Requested by the Governor

House letter send 2/14/2012 Testified on: 2/28/2012 Testified: Bob Cooper

Senate Testified on: 2/7/2012 Testified: Bob Cooper

12 H7323 AN ARTICLE RELATING TO MEDICAID REFORM ACT OF 2008

Rep. Melo Requested by the Governor

House letter send 2/14/2012 Testified on: 2/28/2012 Testified: Bob Cooper

Senate Testified on: 2/7/2012 Testified: Bob Cooper

**Legislation Committee finds this bill Beneficial
Scheduled for hearing and/or consideration**

House Judiciary Committee

Next Action on: 4/10/2012@ Rise, in House Lounge

12 H7173 AN ACT RELATING TO PROPERTY - RHODE ISLAND FAIR HOUSING PRACTICES ACT

Rep. Blazewski

Identical to S 2052

House letter send 2/14/2012

House Finance Committee

Next Action on: 4 /25/2012 @ Rise, in room 35

12 H7028 AN ACT RELATING TO BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS - RIGHTS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Rep. O'Grady

Similar to H 7035 Sections 1

House letter send 2/21/2012

12 H7032 AN ACT RELATING TO HUMAN SERVICES -- DEVELOPMENTAL DISABILITIES FUNDING

Rep. Hull

Similar to H 7035 Section 3

House letter send 2/14/2012

12 H7033 JOINT RESOLUTION RELATING TO MAKING APPROPRIATIONS FOR THE SUPPORT OF THE STATE FOR THE FISCAL YEAR ENDING JUNE 30, 2012

Rep. McNamara

Similar to H 7034 and S 2037

House letter send 2/21/2012

12 H7034 JOINT RESOLUTION MAKING AN APPROPRIATION OF \$15,000,000 FOR SERVICES FOR THE DEVELOPMENTALLY DISABLED

Rep. O'Grady

Similar to H 7033 and S 2037

House letter send 2/21/2012

12 H7035 AN ACT RELATING TO BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS - RIGHTS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Rep. Gurthrie

Similar to H 7032 & 7028

House letter send 2/21/2012

12 H7106 AN ACT RELATING TO HUMAN SERVICES -- DEVELOPMENTAL DISABILITIES FUNDING

Rep. Bennett

Similar to H 7032 & 7028

House letter send 3/8 /2012 Testimony Requested - Yes

Referred to Committee

House Finance Committee

12 H7420 JOINT RESOLUTION RELATING TO MAKING APPROPRIATIONS FOR THE SUPPORT OF THE STATE FOR THE FISCAL YEAR ENDING JUNE 30, 2012

Rep. Gordon

House letter send 2/14/2012 Testimony Requested - Yes

Senate Finance Committee

12 S2037 AN ACT RELATING TO MAKING APPROPRIATIONS FOR THE SUPPORT OF THE STATE FOR THE FISCAL YEAR ENDING JUNE 30, 2012

Sen. Tassoni

Similar to H 7033 and H 7034

Senate letter send 3/8/2012

12 S2041 AN ACT RELATING TO HUMAN SERVICES -- DEVELOPMENTAL DISABILITIES FUNDING

Sen. Tassoni

Similar to H 7032 & 7028

Senate letter send 2/21/2012

12 S2466 JOINT RESOLUTION MAKING AN APPROPRIATION OF \$15,000,000 FOR SERVICES FOR THE DEVELOPMENTALLY DISABLED

Sen. Doyle Similar to H 7033 and H 7034
Senate letter send 2/21/2012
12 S2467 AN ACT RELATING TO BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS - RIGHTS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Sen. Doyle Similar to H 7035 Sections 1
Senate letter send 2/21/2012
Senate Health and Human Services Committee
12 S2638 AN ACT RELATING TO INSURANCE - INSURANCE COVERAGE FOR MENTAL ILLNESS AND SUBSTANCE ABUSE

Sen. Doyle Identical to H 7785
Senate letter send 3/13/2012
Senate Judiciary Committee
12 S2338 AN ACT RELATING TO PROPERTY -- RHODE ISLAND FAIR HOUSING PRACTICES ACT

Sen. Metts,
Senate letter send 2/14/2012

Held for Further Study, Continued, or Heard

House Corporations Committee
12 H7785 AN ACT RELATING TO INSURANCE - COVERAGE FOR MENTAL ILLNESS AND SUBSTANCE ABUSE Identical to S 2638
Rep. Ajello
House letter send 3/13/2012
12 H7795 AN ACT RELATING TO PUBLIC UTILITIES AND CARRIERS

Rep. Gallison
House letter send 3/13/2012
House Finance Committee
12 H7323 AN ARTICLE RELATING TO TAXATION AND REVENUES
Rep. Melo Requested by the Governor

House letter send 2/14/2012
House Health, Education, & Welfare Committee
12 H7540 AN ACT RELATING TO PUBLIC UTILITIES AND CARRIERS - ACCESS TO TELEPHONE INFORMATION SERVICES FOR DISABLED PERSONS

Rep. Naughton
House letter send 2/21/2012
12 H7734 AN ACT RELATING TO HUMAN SERVICES - PERSONAL CARE ATTENDANT PROGRAM
Rep. Naughton Requested by the Attorney General
House letter send 2/21/2012 Testified on: 3/14/2012 Testified: Linda Ward

Senate Health and Human Services Committee
12 S2321 AN ACT RELATING TO HUMAN SERVICES - EQUAL RIGHTS OF BLIND AND DEAF PERSONS TO PUBLIC FACILITIES

Sen. Gallo Identical to S 2327 & H 7445
Senate letter send 2/14/2012
12 S2327 AN ACT RELATING TO HUMAN SERVICES - EQUAL RIGHTS OF BLIND AND DEAF PERSONS TO PUBLIC FACILITIES

Sen. Walaska Identical to S 2321 & H 7445
Senate letter send 2/14/2012:
12 S2360 AN ACT RELATING TO INSURANCE-ACCIDENT AND SICKNESS INSURANCE POLICIES

Sen. Nesselbush Similar to S 2360 & H 7327 &
Senate letter send 2/14/2012
12 S2428 AN ACT RELATING TO INSURANCE - COVERAGE FOR PRESCRIPTION DRUGS
Sen. Crowley Similar to H 7327 & S 2360

Senate letter send 2 28/2012
Senate Housing and Municipal Government Committee
12 S2052 AN ACT RELATING TO PROPERTY - RHODE ISLAND FAIR HOUSING PRACTICES ACT
Sen. Tassoni Identical to H 7173
Senate letter send 2/14/2012

Recommend Passage

House Calendar
Next Action on: 4/10/2012 #002
12 H7445 AN ACT RELATING TO HUMAN SERVICES - EQUAL RIGHTS OF BLIND AND DEAF PERSONS TO PUBLIC FACILITIES

Rep. Handy
House letter send 2/14/2012

Identical to S 2321 and 2327

Transferred

House Finance Committee

12 H7327 AN ACT RELATING TO INSURANCE-ACCIDENT AND SICKNESS INSURANCE POLICIES

Rep. Corvese

Similar to S 2428 & S 2360

House letter send 3/14/2012

**Legislation Committee finds this bill Beneficial if amended
Held for Further Study, Continued, or Heard**

House Health, Education, & Welfare Committee

12 H7446 AN ACT RELATING TO PUBLIC UTILITIES AND CARRIERS - PUBLIC UTILITIES COMMISSION

Rep. Naughton

Identical to S 2707

House letter send 2/15/2012

House Labor Committee

12 H7862 AN ACT RELATING TO LABOR AND LABOR RELATIONS - TEMPORARY DISABILITY INSURANCE - BENEFITS

Rep. Coderre

House letter send 3/13/2012

House Municipal Government Committee

12 H7352 AN ACT RELATING TO HIGHWAYS

Rep. Martin

Identical to S 2131

House letter send 2/14/2012 Testified on: 4/5/2012 Testified: Bob Cooper

Senate Corporations Committee

12 S2707 AN ACT RELATING TO PUBLIC UTILITIES AND CARRIERS - PUBLIC UTILITIES COMMISSION

Sen. Gallo

Identical to H 7466

Senate letter send 3/8/2012

Passed and Referred to

House Municipal Government Committee

12 S2131 AN ACT RELATING TO HIGHWAYS

Sen. DiPalma

Identical to H 7352

House letter send 3/14/2012

Senate letter send 2/14/2012

**Legislation Committee finds this bill Harmful
Referred to Committee**

Senate Health and Human Services Committee

Next Action on:

12 S2076 AN ACT RELATING TO INSURANCE - AUTISM SPECTRUM DISORDERS

Sen. O'Neill

Identical to H 7165 & S 2560

House letter send 3/13/2012

Senate Judiciary Committee

12 S2250 AN ACT RELATING TO MOTOR AND OTHER VEHICLES -- PARKING FACILITIES AND PRIVILEGES

Sen. Kettle

Identical to S 2363 & H 7200

Senate letter send 3/5 /2012

Held for Further Study, Continued, or Heard

House Corporations Committee

12 H7572 AN ACT RELATING TO PUBLIC PROPERTY AND WORKS -- STATE PURCHASES

Rep. Trillo

House letter send 3/13/2012

12 H7797 AN ACT RELATING TO INSURANCE - MANDATED BENEFITS

Rep. Morgan

House letter send 3/13/2012 Testified on: 3/21/2012 Testified: Jessica Burrows

House Health, Education, & Welfare Committee

12 H7165 AN ACT RELATING TO INSURANCE - AUTISM SPECTRUM DISORDERS

Rep. Palumbo

Identical to S 2076 & S 2560

House letter send 3/13/2012

12 H7200 AN ACT RELATING TO MOTOR AND OTHER VEHICLES -- PARKING FACILITIES AND PRIVILEGES

Rep. Costa

Identical to S 2363 & S 2250

House letter send 2/14/2012

12 H7655 AN ACT RELATING TO EDUCATION -- CHILDREN WITH DISABILITIES

Rep. Naughton
House letter send 3/13/2012
House Judiciary Committee
12 H7555 AN ACT RELATING TO PUBLIC RECORDS - ACCESS TO PUBLIC RECORDS
Rep. Marcella Similar to H 7838 & S 2652
House letter send 3/13/2012 Testified on: 4/3/2012 Testified: Bob Cooper
12 H7838 AN ACT RELATING TO PUBLIC RECORDS - ACCESS TO PUBLIC RECORDS
Rep. Lally Requested by the Attorney General Identical to S 2652, Similar to
House letter send 3/13/2012 Testified on: 4/3 /2012 Testified: Bob Cooper
House Municipal Government Committee
12 H7907 AN ACT RELATING TO BEHAVIORAL HEALTH CARE DEVELOPMENTAL DISABILITIES AND HOSPITALS - GROUP HOMES
Rep. Newberry
House letter send 3/13/2012
Senate Health and Human Services Committee
12 S2560 AN ACT RELATING TO INSURANCE -- AUTISM SPECTRUM DISORDERS
Sen. O'Neill Identical to H 7165 & S 2076
Senate letter send 3/13/2012
Senate Housing and Municipal Government Committee
12 S2363 AN ACT RELATING TO MOTOR AND OTHER VEHICLES -- PARKING FACILITIES AND PRIVILEGES
Sen. Doyle Identical to S 2250
Senate letter send 2/14/2012 Testified on: 3/27/2012 Testified: Spoke to Cmte. Chair and provided written testimony
Senate Judiciary Committee
12 S2652 AN ACT RELATING TO PUBLIC RECORDS - ACCESS TO PUBLIC RECORDS
Sen. Sheehan Requested by the Attorney General Identical to H 7838 & Similar
Senate letter send 3 13/2012

Legislation Committee finds this bill Harmful unless amended
Scheduled for hearing and/or consideration

House Finance Committee

Next Action on: 5/1/2012@ 1 PM, in Room 35

12 H7806 AN ACT RELATING TO STATE AFFAIRS AND GOVERNMENT
Rep. Naughton Requested by the Attorney General
House letter send 3/13/2012 Tim Flynn & Bob Cooper spoke to Sponsor on 4/5/2012

	Consideration of New Bills/Budget Articles	Review Requester	3:30
Purpose/Goal: To review recently introduced bills to determine their impact on people with disabilities and their families.			
Disability Prevention Bills, Review requested by Gwen Reeve Referred to House Health, Education, & Welfare Committee 12 H7986 AN ACT RELATING TO HEALTH AND SAFETY -- CHILDREN'S PRODUCT SAFETY ACT by Rep. Tanzi This act would ban the use of cadmium, mercury or lead in children's products. This act would take effect upon passage.			

- 1-1 SECTION 1 Chapter 23-75 of the General Laws entitled "Children's Product Safety Act"
- 1-2 is hereby amended by adding thereto the following section:
- 1-3 ^(add) **23-75-3.5. Cadmium, Mercury and Lead in Children's Products - Prohibition. -- (a)**
- 1-4 After June 30, 2013, no person shall manufacture, sell, offer for sale, import or otherwise
- 1-5 distribute in the state any children's product that contains cadmium, mercury or lead.
- 1-6 (b) As used in this section:
- 1-7 (1) "Cadmium" means elemental cadmium and any compounds or alloys that contain
- 1-8 cadmium.
- 1-9 (2) "Mercury" means elemental mercury and any compounds or alloys that contain
- 1-10 mercury.
- 1-11 (3) "Lead" means elemental lead and any compounds or alloys that contain lead.
- 1-12 (4) "Children's product" means any consumer product or component thereof that is

1-13 designed and intended primarily for use by children under twelve (12) years of age, including, but
1-14 not limited to, jewelry, clothing and accessories, decorative objects, backpacks, candy, food,
1-15 dietary supplements and other edible or chewable items, toys, furniture, or other articles used by
1-16 or intended to be used by children.

1-17 (c) Any manufacturer, distributor, or importer of a children's product intended for use by
1-18 a child under twelve (12) years of age, who discovers that the children's product contains, is
1-19 composed of, or is made with lead, mercury, or cadmium, shall issue an immediate recall for that
1-20 children's product.

2-1 (d) The director of the department of health shall issue an immediate recall for any
2-2 children's product intended for use by a child under the age of twelve (12), when he or she
2-3 discovers contains, is composed of, or is made with lead, mercury, or cadmium.

2-4 (e) Within forty-eight (48) hours of receiving notice from the director of the department
2-5 of health or a manufacturer, distributor, or importer that a children's product intended for use by a
2-6 child under the age of twelve (12) has been recalled because it contains, is composed of, or is
2-7 made with lead, mercury, or cadmium, a retail mercantile establishment shall remove the
2-8 children's product from any display and make it unavailable for purchase.

2-9 (f) Within fourteen (14) business days of receiving notice from the director of the
2-10 department of health or a manufacturer, distributor, or importer that a children's product intended
2-11 for use by a child under the age of twelve (12) has been recalled because it contains, is composed
2-12 of, or is made with lead, mercury, or cadmium, a retail mercantile establishment shall return all
2-13 inventory of that children's product to the manufacturer, distributor, or importer from which it
2-14 was obtained, at the cost of the manufacturer, distributor, or importer.

2-15 (g) Within sixty (60) business days of receiving a children's product intended for use by
2-16 a child under the age of twelve (12) that has been recalled because it contains, is composed of, or
2-17 is made with lead, mercury, or cadmium from a retail mercantile establishment, the manufacturer,
2-18 distributor, or importer shall destroy the children's product in such a way that renders it useless,
2-19 and dispose of the remnants in a manner and location designed to remove them from access by
2-20 the general public.

2-21 (h) Any manufacturer, distributor, importer, mercantile establishment or person who
2-22 violates any provision of this section shall be subject to an administrative penalty of not more
2-23 than one thousand dollars (\$1,000). Each day that the violation continues or exists shall constitute
2-24 separate offense. Any revenues received pursuant to this chapter shall be deposited as general
2-25 revenues.

2-26 (i) The director of the department of health may adopt rules according to the provisions
2-27 of chapter 42-35, including rules that provide for product testing and enforcement of this section. ^{add}

2-28 SECTION 2. This act shall take effect upon passage.



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MOTION: To find beneficial 12 H7986 AN ACT RELATING TO HEALTH AND SAFETY -- CHILDREN'S PRODUCT SAFETY ACT RC/AP Passed, BI Abstained

Held for Further Study in House Health, Education, & Welfare Committee

12 H 7992 A N ACT RELATING TO STATE AFFAIRS AND GOVERNMENT - RHODE ISLAND PREVENTION, HEALTH PROMOTION, AND PUBLIC HEALTH COUNCIL by Rep. Naughton

This act would create the Rhode Island prevention, health promotion and public health council. There would be 21 members, with the director of the Department of Health serving as the chairperson. The mission of this council would be to provide state level coordination and leadership, among all state departments and agencies on the topics of prevention, wellness and health promotion practices, public health system and integrative healthcare. They also would be tasked with developing a statewide strategy in those areas, to improve overall health in the state and reduce the incidence of preventable illness, as well as providing recommendations to the Governor.

This act would take effect upon passage.

1-1 SECTION 1. Title 42 of the General Laws entitled "STATE AFFAIRS AND
1-2 GOVERNMENT" is hereby amended by adding thereto the following chapter:

1-3 ^(add) **CHAPTER 18.2**

1-4 **RHODE ISLAND PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH**
1-5 **COUNCIL**

1-6 **42-18.2-1. Establishment of Council.** – There is hereby established a Rhode Island
1-7 prevention, health promotion, and public health council (hereafter referred to as “the council”).
1-8 The department of health shall grant to the council reasonable access to appropriate staff.

1-9 **42-18.2-2. Composition of the Council.** – (a) The council shall have twenty-one (21)
1-10 members as follows: (1) The director of the department of health, who shall serve as chairperson
1-11 of the board; (2) The director of the department of labor and training; (3) The secretary of health
1-12 and human services; (4) The director of the department of environmental management; (5) The
1-13 commissioner of elementary and secondary education; (6) The director of the department of
1-14 administration; (7) The director of the division of agriculture; (8) The director of the economic
1-15 development corporation; (9) The director of the department of transportation; (10) The president
1-16 of the University of Rhode Island; (11) The associate dean of the public health program of Brown
1-17 University; (12) The dean of the college of pharmacy; (13) The president of the Rhode Island
1-18 medical society; (14) The president of the Rhode Island dental society; (15) The president of the
1-19 Rhode Island nursing association; (16) The president of the hospital association of Rhode Island;
2-1 (17) The president of the Rhode Island health centers association; (18) The president of the
2-2 Rhode Island public health association; (19) The president of the Rhode Island public health
2-3 institute; (20) The president of the league of cities and towns; (21) The head of any other state
2-4 established agency that the chairperson determines is appropriate.

2-5 (b) Ten (10) members shall constitute a quorum. A majority vote of the council shall be
2-6 required for all recommendations, advice, and approvals of the council in accordance with this
2-7 chapter.

2-8 (c) Members from state government shall serve in an ex officio capacity as long as they
2-9 are eligible.

2-10 (d) The council may establish subcommittees and advisory bodies as deemed necessary
2-11 by the members.

2-12 **42-18.2-3. Meetings of the council.** – The council shall meet at the call of the chair, no
2-13 less than quarterly.

2-14 **42-18.2-4. Purpose and Duties.** – The council shall:

2-15 (1) Provide coordination and leadership at the state level, and among all state departments
2-16 and agencies, with respect to prevention, wellness and health promotion practices, the public
2-17 health system, and integrative health care in Rhode Island;

2-18 (2) Develop a statewide prevention, health promotion, public health, and integrative
2-19 health care strategy that incorporates the most effective and achievable means of improving the
2-20 health status of Rhode Islanders and reducing the incidence of preventable illness and disability
2-21 across the state;

2-22 (3) Provide recommendations to the governor and the general assembly concerning the
2-23 most pressing health issues confronting the state and changes in state policy to achieve wellness,
2-24 health promotion, and public health goals, including the reduction of tobacco use, sedentary
2-25 behavior, and poor nutrition;

2-26 (4) Consider and propose evidence-based models, policies, and innovative approaches for
2-27 the promotion of transformative models of prevention, integrative health, and public health on
2-28 individual and community levels across the state;

2-29 (5) Submit annual reports required under section 6 of this chapter;

2-30 (6) Carry out other activities determined appropriate by the governor or as requested by
2-31 the general assembly; and

2-32 (7) Make available to the public all information about activities of the council.

2-33 **42-18.2-5. Rhode Island Preventative Strategy.** – Not later than one year after the date
2-34 of enactment of this chapter, the chairperson, in consultation with the council, shall develop and
3-1 make public a Rhode Island prevention, health promotion and public health strategy, and shall
3-2 review and revise such strategy periodically. Such strategy shall:

3-3 (1) Set specific goals and objectives for improving the health of Rhode Island through
 3-4 prevention, health promotion, and public health programs, consistent with ongoing goal setting
 3-5 efforts conducted by specific agencies;
 3-6 (2) Establish specific and measurable actions and timelines to carry out the strategy, and
 3-7 determine accountability for meeting those timelines, within and across state departments and
 3-8 agencies; and
 3-9 (3) Make recommendations to improve staff efforts relating to prevention, health
 3-10 promotion, public health, and integrative health care practices to ensure state efforts are
 3-11 consistent with available standards and evidence.
 3-12 **42-18.2-6. Annual Report.** – (a) Not later than January 1, 2014, and annually thereafter,
 3-13 the council shall submit to the governor and the general assembly, a report that:
 3-14 (1) Describes the activities and efforts on prevention, health promotion, and public health
 3-15 and activities to develop and/or revise the state prevention strategy conducted by the council
 3-16 during the period for which the report is prepared;
 3-17 (2) Describes the progress in meeting specific prevention, health promotion, and public
 3-18 health goals defined in the strategy and further describes corrective actions recommended by the
 3-19 council and taken by relevant agencies and organizations to meet these goals;
 3-20 (3) Contains a list of state priorities on health promotion and disease prevention to
 3-21 address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise,
 3-22 mental health, behavioral health, substance use disorder, and domestic violence screenings) and
 3-23 the prevention measures for the five (5) leading disease killers in Rhode Island; and
 3-24 (4) Contains specific science-based initiatives to achieve the measurable goals of the
 3-25 prevention strategy regarding nutrition, exercise, and smoking cessation, and targeting the five (5)
 3-26 leading disease killers in Rhode Island.
 3-27 (b) The director of health shall address a joint session of the general assembly during the
 3-28 month of January or February of each year, at the invitation of the speaker of the house, to present
 3-29 the key findings and recommendations of the annual report.
 3-30 **42-18.2-7. Applicability of other laws.** – The council, as well as any subcommittees or
 3-31 advisory bodies it may establish, shall be subject to the provisions of chapter 38-2, access to
 3-32 public records act, and chapter 42-46, open meetings act.
 3-33 **42-18.2-8. Severability.** – If any provision of this chapter or the application of this
 3-34 chapter to any person or circumstances is held invalid, the invalidity shall not affect other
 4-1 provisions or applications of the chapter, which can be given effect without the invalid provision
 4-2 or application, and to this end the provisions of this chapter are declared to be severable.^{add}
 4-3 SECTION 2. This act shall take effect upon passage.



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MOTION: To find beneficial/ if amended to BHDDH, 3 community based agencies and patient advocates, 12 H 7992 A N ACT RELATING TO STATE AFFAIRS AND GOVERNMENT - RHODE ISLAND PREVENTION, HEALTH PROMOTION, AND PUBLIC HEALTH COUNCIL AP/GR passed unanimously

Review requested by Sharon Brinkworth

12 H 8044 AN ACT RELATING TO MOTOR AND OTHER VEHICLES - MISCELLANEOUS RULES by Rep. Nunes

This act would amend the sunset provision of the 2011 seatbelt law that made violations a primary offense. The date of expiration will change from June 30, 2013 to June 30, 2012. Violations occurring after that date will be a secondary offense.

This act would take effect upon passage.

1-1 SECTION 1. Section 2 of Chapter 185 of the 2011 Public Laws entitled “An Act Relating
 1-2 to Motor and Other Vehicles Safety Belt Use” is hereby amended to read as follows:
 1-3 SECTION 2. This act shall take effect upon passage and it shall expire on June 30, ~~2013~~^{delete}
 1-4 ^{add}2012^{add}.
 1-5 SECTION 2. Section 2 of Chapter 186 of the 2011 Public Laws entitled “An Act Relating

1-6 to Motor and Other Vehicles – Safety Belt Use” is hereby amended to read as follows:
1-7 SECTION 2. This act shall take effect upon passage and it shall expire on June 30, ^{delete}2013^{delete}
1-8 ^{add}2012^{add}.
1-9 SECTION 3. This act shall take effect upon passage.



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MOTION: To find harmful on 12 H 8044 AN ACT RELATING TO MOTOR AND OTHER VEHICLES - MISCELLANEOUS RULES BI/JD passed, Nay AS

Employment Bill, Review requested by Bob Cooper

Held for Further Study in House Labor Committee

12 H 7935 AN ACT RELATING TO LABOR AND LABOR RELATIONS -- ESTABLISHING BACK TO WORK RHODE ISLAND PROGRAM by Rep. Hern

This act would assist employers and potential employees by creating the back to work Rhode Island Program Act of 2012. The department of labor and training would provide workers compensation coverage for participating claimants.

This act would take effect on January 1, 2013.

1-1 SECTION 1. Title 28 of the General Laws entitled "LABOR AND LABOR
1-2 RELATIONS" is hereby amended by adding thereto the following chapter:

^{add}CHAPTER 44.1

BACK TO WORK RHODE ISLAND PROGRAM ACT OF 2012

1-4
1-5 28-44.1-1. Short title. – This act shall be known and may be cited as the “Back to Work
1-6 Rhode Island Program Act of 2012.”

1-7 28-44.1-2. Legislative findings and purpose. – The general assembly hereby finds as
1-8 follows:

1-9 (1) As of January 1, 2012, Rhode Island’s unemployment rate is the highest in the New
1-10 England region and above the national average;

1-11 (2) Despite this high unemployment, businesses report difficulties and frustration in
1-12 locating employment candidates with the requisite knowledge, skills, and abilities they need;

1-13 (3) In an uncertain economy, employers are hesitant to invest in training if there is a risk
1-14 the investment will not result in a qualified and skilled employee;

1-15 (4) Despite the need for skilled employees, job seekers face difficulties in getting their
1-16 “foot in the door” to demonstrate their value to potential employers;

1-17 (5) Statistics indicate that unemployment compensation claimants who participated in
1-18 employer-partnered training programs return to work more quickly than those who do not, and
1-19 that such programs have saved significant sums of employment security funds;

2-1 (6) The purpose of the “Back to Work Rhode Island Program” is to assist employers in
2-2 locating and obtaining skilled and qualified employees at little to no training cost, and to provide
2-3 the opportunity for job seekers to gain a “foot in the door,” gain knowledge, learn new skills, and
2-4 abilities, and receive the opportunity for employment.

2-5 28-44.1-3. Definitions. – For the purposes of this chapter, the following terms shall have
2-6 the following meanings:

2-7 (1) “Claimant” means a person collecting unemployment security benefits under the
2-8 provisions of chapters 28-42 through 28-44;

2-9 (2) “Department” means the Rhode Island department of labor and training;

2-10 (3) “Director” means the director of the Rhode Island department of labor and training;

2-11 (4) “Participating employer” means an employer who has voluntarily agreed to
2-12 participate in the “Back to Work Rhode Island Program” and meets the criteria for participation
2-13 established by this chapter and as determined by the director;

2-14 (5) “Program” means the back to work Rhode Island program established under this
2-15 chapter;

2-16 (6) “Skill enhancement and job training” means the measurable raising to a higher degree
2-17 an individual’s knowledge and execution of a fundamental job function;

2-18 (7) “Unemployment benefits” means the money payable to a claimant for his or her wage
2-19 losses due to unemployment, payable pursuant to chapter 28-44 (“Employment Security-

2-20 Benefits”), and includes any amounts payable pursuant to an agreement under federal law
2-21 providing for compensation, assistance, or allowances with respect to unemployment.
2-22 **28-44.1-4. Back to work Rhode Island program.** – (a) The back to work Rhode Island
2-23 program is hereby established and shall be administered by the department of labor and training.
2-24 (b) The program shall be designed so as to permit a claimant to be matched with an
2-25 employer participating in the program and be placed in an open employment position made
2-26 available by the employer. Participation by both claimant and employer shall be voluntary. The
2-27 employer shall provide the claimant with skill enhancement and job training relevant to the open
2-28 employment position for up to twenty-four (24) hours per week for up to six (6) weeks. Upon
2-29 completion of the six (6) week period, claimants must be considered for employment by the
2-30 employer. During the six (6) week period, the employer shall not compensate the claimant in any
2-31 way other than the training that the claimant receives through participation in the program. An
2-32 employer may terminate participation in the program at any time.
2-33 (c) Notwithstanding any other law, participation in the back to work Rhode Island
2-34 program shall not affect the employment security benefits of a claimant; provided, however, that
3-1 contingent upon appropriation, said claimant may receive a reasonable stipend in an amount
3-2 determined by the director to cover any additional costs associated with their participation in the
3-3 program, including, but not limited to, transportation or childcare costs.
3-4 (d) The department shall notify employers of the availability of the program and shall
3-5 provide employers with information and materials necessary to participate upon request.
3-6 (e) The department shall continuously monitor the program to ensure that participating
3-7 employers enter the program in good faith with the genuine expectation of hiring for the open
3-8 position and with the intent and ability to provide relevant skill enhancement and job training.
3-9 (f) The department shall develop and conduct an orientation program for participating
3-10 claimants and employers informing them of the rules, regulations, opportunities, and limitations
3-11 of the back to work Rhode Island program.
3-12 (g) A claimant may stay in the program if they exhaust benefits or lose program
3-13 eligibility prior to the end of the six (6) weeks; provided, however, once benefits are exhausted or
3-14 program eligibility is lost, unemployment compensation shall be discontinued.
3-15 (h) Participation in the program by a claimant shall be limited to six (6) weeks in any
3-16 benefit year. A claimant shall be encouraged to end a training relationship that is not beneficial
3-17 and shall be encouraged to preserve the remainder of his or her six (6) weeks of training for
3-18 another training opportunity.
3-19 (i) In order to participate, a claimant must be seeking work and must be able, available,
3-20 and accept work during the training period.
3-21 (j) Interested claimants shall be encouraged, but not required, to find employment
3-22 opportunities that align with their current job skills, knowledge and experience. Employers shall
3-23 be encouraged to work with the department to locate claimants with current job skills, knowledge,
3-24 and experience that align with the requirements of an open employment opportunity;
3-25 (k) The claimant and the employer must agree upon a formal training plan and schedule
3-26 which must be approved by the department.
3-27 (l) Participation in the program will be limited to the first two hundred (200) participants
3-28 determined to be eligible by the department.
3-29 (m) The back to work Rhode Island program will expire on December 31, 2013. New
3-30 participants will not be enrolled after November 18, 2013.
3-31 **28-44.1-5. Eligibility to be a participating employer.** – (a) An employer wishing to
3-32 participate in the back to work Rhode Island program shall be required to meet the following
3-33 qualifications:
4-34 (1) The employer must conduct business in Rhode Island; although, the business need not
4-35 be domestic to Rhode Island;
4-36 (2) The employer must have a full-time position of employment available that the
4-37 employer is desirous of filling;
4-38 (3) The employer must be willing and able to provide a participating claimant with skills
4-39 enhancement and job training focused toward the position that is available;
4-40 (4) The employer must certify that he, she, they, or it will not pay any wages or provide

4-41 any payment in kind to the claimant during the course of the claimant's participation in the
 4-42 program;
 4-43 (5) The employer must agree to follow up a claimant's participation in the program with a
 4-44 performance evaluation of the claimant, regardless of whether or not the claimant is hired for
 4-45 employment;
 4-46 (6) The employer must agree to provide information as requested by the department and
 4-47 verify that employment of a participating claimant will not displace nor have any impact on a
 4-48 promotion due an existing employee;
 4-49 (7) The employer must certify that the employment and training opportunity is not due to
 4-50 a lockout, strike, or other labor dispute; and
 4-51 (8) For employers with employees who are subject to collective bargaining, the written
 4-52 approval by the collective bargaining representative for each affected unit shall be required to be
 4-53 included in the plan for any job training for a position which would otherwise be covered by a
 4-54 collective bargaining agreement.
 4-55 **28-44.1-6. Eligibility to be a participating claimant.** – (a) An individual receiving
 4-56 unemployment benefits and wishing to participate in the back to work Rhode Island program
 4-57 must meet the following qualifications:
 4-58 (1) The individual must be eligible to receive Rhode Island unemployment compensation
 4-59 benefits;
 4-60 (2) The individual must continue to file weekly continued claims to receive benefits
 4-61 unless otherwise exempted;
 4-62 (3) The individual must continue to look for work and employment opportunities during
 4-63 their participation in the program, unless otherwise exempt;
 4-64 (4) The individual must certify that he or she understands that participation in the
 4-65 program includes no guarantee of employment;
 4-66 (5) The individual must attend a mandatory orientation to be offered by the department;
 4-67 (6) The individual must agree to provide information as requested by the department; and
 4-68 must agree to report any missed training or changes to the training program.
 5-1 (b) Claimants with a definite recall date within six (6) weeks and those who do not
 5-2 register for employment services are not eligible for the program.
 5-3 **28-44.1-7. Workers' compensation.** – The department will provide workers
 5-4 compensation coverage for participating claimants.
 5-5 **28-44.1-8. Rules and regulations.** – The director shall promulgate such rules and
 5-6 regulations as the director deems necessary to implement the provisions of this chapter.
 5-7 **28-44.1-9. Funding.** – Creation of the back to work Rhode Island program is contingent
 5-8 upon funding.
 5-9 **28-44.1-10. Severability.** – If any of the provisions of this chapter or the application
 5-10 thereof to any persons or circumstances are held invalid, the remainder of this chapter and the
 5-11 application thereof to other persons or circumstances shall not be affected thereby. To that end,
 5-12 the provisions of this chapter are declared to be severable. ^{add}
 5-13 SECTION 2. This act shall take effect on January 1, 2013.



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MOTION: To find beneficial if amended to cover part-time trainees 12 H 7935 AN ACT RELATING TO LABOR AND LABOR RELATIONS -- ESTABLISHING BACK TO WORK RHODE ISLAND PROGRAM BI/JD passed unanimously

Medicaid Bill Review requested by Gwen Reeve

Referred to Senate Finance Committee
 12 S 2755 AN ACT RELATING TO HUMAN SERVICES -- DISABLED CHILDREN'S MEDICAID BUY-IN by Sen. DiPalma

and

Referred to House Health, Education, & Welfare Committee
 12 H 7933 AN ACT RELATING TO HUMAN SERVICES -- DISABLED CHILDREN'S MEDICAID BUY-IN by Rep. Naughton

This would establish a framework for disabled children to buy into the federal Medicaid

program. The goal and purpose would be to require the office of health and human services (OHHS) and its Medicaid office to provide access to children that meet the social security administration's definition of disability.

The OHHS and its Medicaid office would be to authorized and directed to amend (a) its title XIX state plan to initiate a Medicaid buy-in program for children with disabilities and (b) (b) its title XIX state plan to initiate community choice first (Section 2401 in the Affordable Care Act Section 1915 (k) in the Social Security Act). This provision would provide the state additional federal medical assistance program (FMAP) for personal care services for individuals with disabilities in order that parents can be employed and continues employment. This act would take effect upon passage.

1-1 SECTION 1. Title 40 of the General Laws entitled "HUMAN SERVICES" is hereby
1-2 amended by adding thereto the following chapter:

1-3 ^{add} **CHAPTER 8.11**

1-4 **MEDICAID BUY-IN FOR CHILDREN WITH DISABILITIES ACT**

1-5 **40-8.11-1. Short title.** – This chapter shall be known and may be cited as the “Medicaid
1-6 Buy-In for Children with Disabilities Act.”

1-7 **40-8.11-2. Legislative findings.** – The general assembly hereby finds and declares:

1-8 WHEREAS, The National Health Interview Survey (NHIS) census data shows that eight
1-9 percent (8%) of children in this country have significant disabilities, many of whom do not have
1-10 access to critical healthcare services they need.

1-11 WHEREAS, In order for these families to get needed health services for their children,
1-12 many are forced to stay impoverished, become impoverished, put their children in out-of-home
1-13 placements, or simply give up custody of their children so that their child can maintain eligibility
1-14 for health coverage through Medicaid.

1-15 WHEREAS, Children must not have health insurance coverage for six (6) months to
1-16 become eligible for the Children Health Insurance Program (CHIP).

1-17 WHEREAS, The six (6) month lack of health insurance coverage causes children with
1-18 disabilities deterioration of their health status.

1-19 WHEREAS, Families with children with disabilities report they are turning down jobs,
1-20 turning down raises, turning down overtime, and are unable to save money for the future of their
2-1 children and family so that they can stay in the income bracket that qualifies their child for social
2-2 security income and/or Medicaid.

2-3 WHEREAS, The Family Opportunity Act of 2005 was intended to address the two (2)
2-4 greatest barriers preventing families from staying together and staying employed.

2-5 WHEREAS, The Family Opportunity Act, signed into law by congress as part of the
2-6 Deficit Reduction Act of 2005, allows states to offer a Medicaid buy-in program to children with
2-7 disabilities who are not eligible for supplemental security income (SSI) disability benefits due to
2-8 family income requirements, but who do meet the social security childhood disability
2-9 determination qualifications.

2-10 WHEREAS, Through implementation of the Family Opportunity Act, children with
2-11 special healthcare needs may access comprehensive health insurance coverage who are now
2-12 uninsured, and fill in some of the gaps in their coverage through the Medicaid Buy-in program.

2-13 WHEREAS, Only Medicaid can provide these comprehensive services.

2-14 WHEREAS, Through the Medicaid buy-in program disabled children can “buy-in” to
2-15 Medicaid either as their only source of health coverage, or as supplement to private health
2-16 insurance.

2-17 WHEREAS, The state can offer Medicaid buy-in programs and receive federal matching
2-18 funds for the cost of these services.

2-19 WHEREAS, A majority of these children covered by the Family Opportunity Act will
2-20 have private coverage as their primary payer, the Medicaid program will not have to cover
2-21 services such as hospitalization and pharmaceuticals, which are typically the most expensive. The
2-22 majority of costs, as is seen in other states with buy-in programs, rest on copayments, deductibles
2-23 and other out-of-pocket costs currently borne by families of children with disabilities.

2-24 WHEREAS, A Medicaid buy-in program means savings in state spending on other

2-25 sources of coverage for children and youth with disabilities such as uncompensated care, bad debt
2-26 at public hospitals and clinics, as well as education, juvenile justice and social services.

2-27 WHEREAS, Families that are currently forced to limit their income in order to qualify
2-28 for Medicaid may take pay raises, overtime, and promotions without losing their child's health
2-29 coverage. Families who earn too much to qualify for Medicaid, but not enough for private
2-30 insurance may have access to coverage for their children with disabilities. Most significantly,
2-31 fewer families will face the choice of giving up custody or placing their children in institutions in
2-32 order to obtain the healthcare coverage they require.

2-33 **40-8.11-3. Definitions.** – For the purposes of this section, the following terms are defined
2-34 as:

3-1 (1) “Family Opportunity Act” means the federal law enacted as a part of the Deficit
3-2 Reduction Act of 2005, Public Law 109-171; Stat. 442 U.S.C. 1396.

3-3 (2) “Children with disabilities” means having a physical and/or mental impairment that is
3-4 disabling under the social security administration's childhood disability definition.

3-5 (3) “Disability determinations” means one made by the medical eligibility determination
3-6 team (MEDT) unless disability has already been established by the social security administration.

3-7 **40-8.11-4. Legislative purpose and policy.** – It shall be the goal and purpose of this
3-8 chapter to require the office of health and human services (OHHS) and its Medicaid office to
3-9 provide access to children that meet the social security administration's definition of disability.

3-10 (a) The OHHS and its Medicaid office are hereby authorized and directed to amend its
3-11 title XIX state plan to initiate a Medicaid buy-in program for children with disabilities.

3-12 (b) The OHHS and its Medicaid office are hereby authorized and directed to amend its
3-13 title XIX state plan to initiate community choice first (Section 2401 in the Affordable Care Act
3-14 Section 1915 (k) in the Social Security Act). This provision provides states with an additional
3-15 federal medical assistance program (FMAP) for personal care services for individuals with
3-16 disabilities in order that parents can be employed and continues employment.

3-17 **40-8.11-5. Implementation.** – (a) Medicaid coverage to children less than nineteen (19)
3-18 years of age for families with incomes up to three hundred percent (300%) of the federal poverty
3-19 level receive federal match. This coverage may be a child's only health care coverage or
3-20 supplemental to private insurance.

3-21 (b) The state may require families to pay monthly premiums based on a sliding scale. If
3-22 parents have employer-provided health plans, they are required to apply for, enroll in, and pay
3-23 these premiums (which will reduce the state costs) when the employer contributes at least fifty
3-24 percent (50%) of the annual premium costs. Participation in such an employer-sponsored health
3-25 plan, when available, is a condition of continuing Medicaid coverage.

3-26 (d) The aggregate amount of all premiums paid must not exceed five percent (5%) of a
3-27 family's income for families below two hundred percent (200%) of the federal poverty level and
3-28 seven and one-half percent (7.5%) of a family's income for families between two hundred percent
3-29 (200%) and three hundred percent (300%) of the federal poverty level. The state has the option of
3-30 waiving premiums in the case of undue hardship for families.

3-31 **40-8.11-6. Regulations and commencement of program.** – (a) The OHHS and its
3-32 Medicaid office shall promulgate the rules and regulations necessary to implement the provisions
3-33 of this act by October 30, 2012, and enrollment of children with disabilities in the Medicaid buy-
3-34 in program shall commence on March 1, 2013.

4-1 (b) The department shall report to the governor and the general assembly on or before
4-2 December 31, 2013 and annually thereafter, with regard to the effectiveness of this chapter in
4-3 achieving its purpose which report shall include, but not be limited to:

4-4 (1) The number of applications for the children's Medicaid buy-in, the number of
4-5 beneficiaries approved who are new to Medicaid, the number of beneficiaries who were in
4-6 another Medicaid eligibility category just prior to the children's Medicaid buy-in, and
4-7 beneficiaries who have or have access to employer-based health insurance coverage;

4-8 (2) Demographics including: age; sex; employment supports provided; and primary
4-9 disabling condition, as permissible under the health insurance portability and accountability act of
4-10 1996 (HIPAA) privacy and security rules; prior and current participation in other public programs
4-11 including Medicare, social security disability insurance (SSDI), supplemental security income

4-12 (SSI), including the 1619 (b) provision; statistics regarding the number of beneficiaries employed,
4-13 and the average wage of those beneficiaries prior to and post Medicaid buy-in eligibility;
4-14 Statistics regarding the amounts of premiums collected; Medicaid claims data including pre-buy-
4-15 in, while on the buy-in, and if disenrolled, after buy-in; and

4-16 (3) Findings and recommendations with regard to any improvements, amendments, or
4-17 changes that should be considered to make the act more effective in achieving its purposes or
4-18 which may be necessary in order to encourage more Medicaid beneficiaries parents to seek and
4-19 retain employment;

4-20 **40-8.11-7. Application and appeals process.** – (a) The director, or his or her designee,
4-21 shall review each application for benefits filed in accordance with regulations, and shall make a
4-22 determination of whether the application will be honored and the extent of the benefits to be made
4-23 available to the applicant, and shall within thirty (30) days after the filing notify the applicant, in
4-24 writing, of the determination. If the application is rejected, the notice to the applicant shall set
4-25 forth therein the reason therefor. The director may at any time reconsider any determination.

4-26 (b) Any applicant aggrieved because of a decision, or delay in making a decision, shall be
4-27 entitled to an appeal and shall be afforded reasonable notice and opportunity for a fair hearing
4-28 conducted by the director.

4-29 (c) Findings of fact by the director shall be final and his or her decision shall be subject to
4-30 judicial review only by certiorari if the decision is arbitrary, capricious, or unreasonable or
4-31 inconsistent with law.

4-32 **40-8.11-8. Annual program evaluation report.** – (a) The office of health and human
4-33 services shall annually prepare a report for the state senate and house of representatives finance
4-34 committees which evaluates the Medicaid buy-in program.

5-1 (b) The report shall include, but not be limited to, the following:

5-2 (1) Comparison of employment incomes for the buy-in participants who enrolled in
5-3 Medicaid change after they enrolled in the buy-in.

5-4 (2) The demographic information:

5-5 (i) Primary disabling condition;

5-6 (ii) Prior and current participation in other programs such as social security disability
5-7 insurance; supplemental security income (including the 1819(b) provision) and Medicare;

5-8 (iii) Pre buy-in earned income;

5-9 (iv) Family earnings while participating in this buy-in;

5-10 (v) Hours worked; and

5-11 (vi) Availability of employer-provided health insurance coverage.

5-12 (3) The comparison of expenditures between primary disability for new Medicaid buy-in
5-13 participants and participants who transferred from another Medicaid eligibility pursuant to this
5-14 buy-in program.

5-15 (4) Disenrollment information as to why participants leave this program and what other
5-16 Medicaid medical coverage they acquire.

5-17 (5) Whether disenrollees return to this buy-in program after a period of time off.

5-18 (6) Findings and recommendations based upon the best practices used in New England
5-19 and throughout the nation concerning:

5-20 (i) The best practices to increase employment opportunities for the parents of disabled
5-21 Medicaid children beneficiaries;

5-22 (ii) The best ways to support the working parents of disabled children;

5-23 (iii) The best strategies to ensure that supportive employment policies are integrated into
5-24 the state's design and implementation of the following:

5-25 (A) Long-term affordable care act;

5-26 (B) Balancing incentive payments plan (BIPP);

5-27 (C) Section 1915(i) State plan amendment;

5-28 (D) Section 2400 community first choice (CFC);

5-29 (E) Section 2703 health homes for individuals with chronic conditions;

5-30 (F) Money follows the person; and

5-31 (G) The dual eligible integrated care plan.

5-32 SECTION 2. This act shall serve as a joint resolution required pursuant to Rhode Island

5-33 general laws section 42-12-12.4-1, et seq.

6-34 WHEREAS, The General Assembly enacted Chapter 12.4 of Title 42 entitled “The
6-35 Rhode Island Medicaid Reform Act of 2008”; and

6-36 WHEREAS, Rhode Island General Law section 42-12.4-7 provides that any change that
6-37 requires the implementation of a rule or regulation or modification or a rule or regulation in
6-38 existence prior to the implementation of the global consumer choice section 1115 demonstration
6-39 (“the demonstration”) shall require prior approval of the general assembly; and further provides
6-40 that any category II change or category III change as defined in the demonstration shall also
6-41 require prior approval to the general assembly; and

6-42 WHEREAS, Rhode Island General Law section 42-7.2-5 states that the secretary of the
6-43 office of health and human services is responsible for the “review and coordination of any global
6-44 consumer choice and human services is responsible for the review and coordination of any global
6-45 consumer choice compact waiver requests and renewals as well as any initiatives and proposals
6-46 requiring amendments to the Medicaid state plan or category I or II changes” as described in the
6-47 demonstration, with “the potential to affect the scope, amount, or duration of publicly-funded
6-48 health care services, provider payments or reimbursements, or access to or the availability of
6-49 benefits and services provided by Rhode Island general and public laws”; and

6-50 WHEREAS, In pursuit of a more cost-effective consumer choice system of care that is
6-51 fiscally sound and sustainable, the secretary requests that the following proposal to amend the
6-52 demonstration be approved by the general assembly: The OHHS proposes determination of
6-53 eligibility and premiums for families of children with disabilities enrolled in the Medicaid buy-in
6-54 program; now, therefore, be it

6-55 RESOLVED, That the general assembly hereby approves the changes set forth in the
6-56 proposal listed above to amend the demonstration; and be it further

6-57 RESOLVED, That the secretary of the office of health and human services is authorized
6-58 to pursue and implement any such necessary waiver amendments, category II or category III
6-59 changes, state plan amendments and/or changes to the applicable department's rules, regulations
6-60 and procedures approved herein and as authorized by section 42-12.4-7. ^{add}

6-61 SECTION 3. This act shall take effect upon passage.



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**MOTION: To find beneficial 12 S 2755 & 12 H 7933 ACTS RELATING TO
HUMAN SERVICES -- DISABLED CHILDREN'S MEDICAID BUY-IN AP/GR
passed unanimously**

Health Insurance Review requested by Gwen Reeve

Referred to Senate Health and Human Services Committee

12 S 2761 AN ACT RELATING TO INSURANCE -- ESTABLISHING MINIMUM PHYSICIAN
REIMBURSEMENT RATES FOR PAYMENTS FROM COMMERCIAL HEALTH INSURERS
by Sen. Goodwin

This act would require health insurers to compensate physicians in underserved areas taking
Medicare recipients at 140% of the rate paid by Medicare for the same service.

This act would take effect upon passage.

1-1 SECTION 1. Title 27 of the General Laws entitled "INSURANCE" is hereby amended
1-2 by adding thereto the following chapter:

^{add} **CHAPTER 69.1**

MINIMUM PHYSICIAN PAYMENTS ACT OF 2012

1-5 **27-69.1-1. Short title.** – This chapter shall be known and may be cited as the "Minimum
1-6 Physician Payments Act of 2012" or "MPPA."

1-7 **27-69.1-2. Legislative findings.** – The general assembly hereby finds and declares as
1-8 follows:

1-9 (1) Most Rhode Island physicians are paid substantially less by commercial health
1-10 insurers than are physicians providing the same services in Connecticut and Massachusetts;

1-11 (2) This payment inequity has made it difficult to recruit and retain physicians in Rhode
1-12 Island;

1-13 (3) The inability to recruit and retain sufficient numbers of physicians poses a long-term
1-14 threat to Rhode Islanders' ability to access high quality medical care;
1-15 (4) The federal Medicare program has a well established and generally fair method for
1-16 determining physician reimbursement;
1-17 (5) Commercial health insurers in Massachusetts and Connecticut generally reimburse
1-18 physicians at greater rates than does Medicare; and
2-19 (6) This chapter is necessary, proper and constitutes an appropriate exercise of the
2-20 authority of this state to regulate the delivery of health care services in order to safeguard the
2-21 public health and safety of Rhode Islanders.
2-22 **27-69.1-3. Definitions.** – The following words and phrases, when used in this chapter,
2-23 shall have the meanings given to them in this section unless the context clearly indicates
2-24 otherwise:
2-25 (1) "Department" means the Rhode Island department of health.
2-26 (2) "Eligible physician" means any person licensed as a physician by the department
2-27 pursuant to chapter 5-37, who is a participating provider in Rhode Island medical assistance and
2-28 RItCare and certifies to the director of the department annually that at least five percent (5%) of
2-29 the care provided by the physician is free care as defined by the department.
2-30 (3) "Health care insurer" means a health care insurer whose premiums are paid in whole
2-31 or in part by employers and as otherwise defined in section 27-20.6-1, including any health care
2-32 insurer affiliate or third-party administrator interacting with hospitals and enrollees on behalf of
2-33 such an insurer, but specifically not including the following types of insurance policy:
2-34 (i) Hospital confinement indemnity;
2-35 (ii) Disability income;
2-36 (iii) Accident only;
2-37 (iv) Long-term care;
2-38 (v) Medicare supplement;
2-39 (vi) Limited benefit health;
2-40 (vii) Specified disease indemnity;
2-41 (viii) Sickness or bodily injury or death by accident or both;
2-42 (ix) Other limited benefit policies; and
2-43 (x) Health care insurance issued or administered by a small health care insurer.
2-44 (4) "Health care insurer affiliate" means a health care insurer that is affiliated with
2-45 another entity by either the insurer or entity having a five percent (5%) or greater, direct or
2-46 indirect, ownership or investment interest in the other through equity, debt or other means.
2-47 **27-69.1-4. Minimum payments.** – (a) Health insurers shall reimburse eligible physicians
2-48 no less than one hundred twenty-five percent (125%) of what Medicare would pay the physician
2-49 for providing the same service.
2-50 (b) Nothing in this chapter shall be construed to prohibit a physician, or the physician's
2-51 lawful employer, from contracting with a health insurer to receive greater reimbursement than
2-52 that required under this chapter ^(add)
3-53 SECTION 2. This act shall take effect on January 1, 2013.



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To take no position on 12 S 2761 AN ACT RELATING TO INSURANCE -- ESTABLISHING MINIMUM PHYSICIAN REIMBURSEMENT RATES FOR PAYMENTS FROM COMMERCIAL HEALTH INSURERS, seek clarification of sponsor's intent.

Held for Further Study in House Corporations Committee
12 H 7909 AN ACT RELATING TO INSURANCE -- HEALTH INSURANCE - CONSUMER PROTECTION by Rep. Kennedy, Requested by the Governor & Lt. Governor
This act would establish health insurance rules and standards in addition to, but not inconsistent with, the health insurance standards established in the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010. These rules and standards would include, but are not limited to, prohibitions on

rescission of coverage, discrimination in coverage, and prohibitions on annual and lifetime limits of coverage unless such limits meet set minimum amounts, as well as adding definitions to the chapters covering health insurance.
This act would take effect upon passage.

NOTE: This act makes the same amendment to each of the health insurance laws: Chapters 27-18 Accident and Sickness Insurance Policies; 27-19 Nonprofit Hospital Service Corporations; 27-20 Nonprofit Medical Service Corporations; & 27-41 Health Maintenance Organizations. The first 20 pages are repeated 3 more times.

1-1 SECTION 1. ^(add)Purpose and intent.

1-2 It is the purpose of this act to amend Rhode Island statutes so as to be consistent with
1-3 health insurance consumer protections enacted in federal law. This act is intended to establish
1-4 health insurance rules, standards, and policies pursuant to, in furtherance of, and in addition to the
1-5 health insurance standards established in the Patient Protection and Affordable Care Act of 2010,
1-6 as amended by the Health care and Education Reconciliation Act of 2010. ^(add)

1-7 SECTION 2. Chapter 27-18 of the General laws entitled "Accident and Sickness
1-8 Insurance Policies" is hereby amended by adding thereto the following section:

1-9 ^(add)27-18-1-1. Definitions. – As used in this chapter:

1-10 (1) "Adverse benefit determination" means any of the following: a denial, reduction, or
1-11 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,
1-12 including any such denial, reduction, termination, or failure to provide or make payment that is
1-13 based on a determination of a participant's or beneficiary's eligibility to participate in a plan or to
1-14 receive coverage under a plan, and including, with respect to group health plans, a denial,
1-15 reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a
1-16 benefit resulting from the application of any utilization review, as well as a failure to cover an
1-17 item or service for which benefits are otherwise provided because it is determined to be
1-18 experimental or investigational or not medically necessary or appropriate. The term also includes
1-19 a rescission of coverage determination.

2-20 (2) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010,
2-21 as amended by the Health Care and Education Reconciliation Act of 2010.

2-22 (3) "Commissioner" or "health insurance commissioner" means that individual appointed
2-23 pursuant to section 42-14.5-1 of the general laws.

2-24 (4) "Grandfathered health plan" means any group health plan or health insurance
2-25 coverage subject to 42 USC section 18011.

2-26 (5) "Group health insurance coverage" means, in connection with a group health plan,
2-27 health insurance coverage offered in connection with such plan.

2-28 (6) "Group health plan" means an employee welfare benefit plan, as defined in 29 USC
2-29 section 1002(1), to the extent that the plan provides health benefits to employees or their
2-30 dependents directly or through insurance, reimbursement, or otherwise.

2-31 (7) "Health benefits" or "covered benefits" means medical, surgical, hospital,
2-32 prescription drug, and such other benefits, whether self-funded, or delivered through the purchase
2-33 of insurance or otherwise.

2-34 (8) "Health care facility" means an institution providing health care services or a health
2-35 care setting, including, but not limited to, hospitals and other licensed inpatient centers,
2-36 ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers,
2-37 diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health
2-38 settings.

2-39 (9) "Health care professional" means a physician or other health care practitioner
2-40 licensed, accredited or certified to perform specified health care services consistent with state
2-41 law.

2-42 (10) "Health care provider" or "provider" means a health care professional or a health
2-43 care facility.

2-44 (11) "Health care services" means services for the diagnosis, prevention, treatment, cure
2-45 or relief of a health condition, illness, injury or disease.

2-46 (12) "Health insurance carrier" means a person, firm, corporation or other entity subject
2-47 to the jurisdiction of the commissioner under this chapter. Such term does not include a group

2-48 health plan.
2-49 (13) “Health plan” or “health benefit plan” means health insurance coverage and a group
2-50 health plan, including coverage provided through an association plan if it covers Rhode Island
2-51 residents. Except to the extent specifically provided by the Affordable Care Act, the term “health
2-52 plan” shall not include a group health plan to the extent state regulation of the health plan is pre-
2-53 empted under section 514 of the Employee Retirement Income Security Act of 1974. The term
2-54 also shall not include:
3-1 (A)(i) Coverage only for accident, or disability income insurance, or any combination
3-2 thereof.
3-3 (ii) Coverage issued as a supplement to liability insurance.
3-4 (iii) Liability insurance, including general liability insurance and automobile liability
3-5 insurance.
3-6 (iv) Workers’ compensation or similar insurance.
3-7 (v) Automobile medical payment insurance.
3-8 (vi) Credit-only insurance.
3-9 (vii) Coverage for on-site medical clinics.
3-10 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant to
3-11 Pub. L. No. 104-191, the health insurance portability and accountability act of 1996 (“HIPAA”),
3-12 under which benefits for medical care are secondary or incidental to other insurance benefits.
3-13 (B) The following benefits if they are provided under a separate policy, certificate or
3-14 contract of insurance or are otherwise not an integral part of the plan:
3-15 (i) Limited scope dental or vision benefits.
3-16 (ii) Benefits for long-term care, nursing home care, home health care, community-based
3-17 care, or any combination thereof.
3-18 (iii) Other excepted benefits specified in federal regulations issued pursuant to Pub. L.
3-19 No. 104-191 (“HIPAA”).
3-20 (C) The following benefits if the benefits are provided under a separate policy, certificate
3-21 or contract of insurance, there is no coordination between the provision of the benefits and any
3-22 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the
3-23 benefits are paid with respect to an event without regard to whether benefits are provided with
3-24 respect to such an event under any group health plan maintained by the same plan sponsor:
3-25 (i) Coverage only for a specified disease or illness.
3-26 (ii) Hospital indemnity or other fixed indemnity insurance.
3-27 (D) The following if offered as a separate policy, certificate or contract of insurance:
3-28 (i) Medicare supplement health insurance as defined under section 1882(g)(1) of the
3-29 Social Security Act.
3-30 (ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United
3-31 States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).
3-32 (iii) Similar supplemental coverage provided to coverage under a group health plan.
3-33 (14) “Office of the health insurance commissioner” means the agency established under
3-34 section 42-14.5-1 of the General laws.
4-1 (15) “Rescission” means a cancellation or discontinuance of coverage that has retroactive
4-2 effect for reasons unrelated to timely payment of required premiums or contribution to costs of
4-3 coverage.
4-4 **27-18-2.1. Uniform explanation of benefits and coverage. – (a) A health insurance**
4-5 **carrier shall provide a uniform summary of benefits and coverage explanation and standardized**
4-6 **definitions to policyholders and others required by, and at the times required, by the federal**
4-7 **regulations adopted under section 2715 of the Affordable Care Act. A summary required by this**
4-8 **section shall be filed with the commissioner for approval under Rhode Island general laws section**
4-9 **27-18-8 et seq. The requirements of this section shall be in addition to the requirements of Rhode**
4-10 **Island general laws section 27-18-8 et seq. The commissioner may waive one or more of the**
4-11 **requirements of the regulations adopted under section 2715 of the Affordable Care Act for good**
4-12 **cause shown. The summary must contain at least the following information:**
4-13 (1) Uniform definitions of standard insurance and medical terms.
4-14 (2) A description of coverage and cost sharing for each category of essential benefits and

4-15 other benefits.

4-16 (3) Exceptions, reductions and limitations in coverage.

4-17 (4) Renewability and continuation of coverage provisions.

4-18 (5) A “coverage facts label” that illustrates coverage under common benefits scenarios.

4-19 (6) A statement of whether the policy, contract or plan provides the minimum coverage

4-20 required of a qualified health plan.

4-21 (7) A statement that the outline is a summary and that the actual policy language should

4-22 be consulted; and

4-23 (8) A contact number for the consumer to call with additional questions and the web

4-24 address of where the actual language of the policy, contract or plan can be found.

4-25 (b) The provisions of this section shall apply to grandfathered health plans.

4-26 **27-18-78. Prohibition on rescission of coverage.** – (a)(1) Coverage under a health

4-27 benefit plan subject to the jurisdiction of the commissioner under this chapter with respect to an

4-28 individual, including a group to which the individual belongs or family coverage in which the

4-29 individual is included, shall not be rescinded after the individual is covered under the plan,

4-30 unless:

4-31 (A) The individual or a person seeking coverage on behalf of the individual, performs an

4-32 act, practice or omission that constitutes fraud; or

4-33 (B) The individual makes an intentional misrepresentation of material fact, as prohibited

4-34 by the terms of the plan or coverage.

5-1 (2) For purposes of paragraph (a)(1)(A), a person seeking coverage on behalf of an

5-2 individual does not include an insurance producer or employee or authorized representative of the

5-3 health carrier.

5-4 (b) At least thirty (30) days advance written notice shall be provided to each health

5-5 benefit plan enrollee or, for individual health insurance coverage, primary subscriber, who would

5-6 be affected by the proposed rescission of coverage before coverage under the plan may be

5-7 rescinded in accordance with subsection (a) regardless of, in the case of group health insurance

5-8 coverage, whether the rescission applies to the entire group or only to an individual within the

5-9 group.

5-10 (c) For purposes of this section, “to rescind” means to cancel or to discontinue coverage

5-11 with retroactive effect for reasons unrelated to timely payment of required premiums or

5-12 contribution to costs of coverage.

5-13 (d) This section applies to grandfathered health plans.

5-14 **27-18-79. Prohibition on annual and lifetime limits.** – (a) Annual limits.

5-15 (1) For plan or policy years beginning prior to January 1, 2014, for any individual, a

5-16 health insurance carrier and a health benefit plan subject to the jurisdiction of the commissioner

5-17 under this chapter may establish an annual limit on the dollar amount of benefits that are essential

5-18 health benefits provided the restricted annual limit is not less than the following:

5-19 (A) For a plan or policy year beginning after September 22, 2010, but before September

5-20 23, 2011 – seven hundred fifty thousand dollars (\$750,000);

5-21 (B) For a plan or policy year beginning after September 22, 2011, but before September

5-22 23, 2012 – one million two hundred fifty thousand dollars (\$1,250,000); and

5-23 (C) For a plan or policy year beginning after September 22, 2012, but before January 1,

5-24 2014 – two million dollars (\$2,000,000).

5-25 (2) For plan or policy years beginning on or after January 1, 2014, a health insurance

5-26 carrier and a health benefit plan shall not establish any annual limit on the dollar amount of

5-27 essential health benefits for any individual, except:

5-28 (A) A health flexible spending arrangement, as defined in Section 106(c)(2)(i) of the

5-29 Internal Revenue Code, a medical savings account, as defined in section 220 of the Internal

5-30 Revenue Code, and a health savings account, as defined in Section 223 of the Internal Revenue

5-31 Code are not subject to the requirements of subdivisions (1) and (2) of this subsection.

5-32 (B) The provisions of this subsection shall not prevent a health insurance carrier and a

5-33 health benefit plan from placing annual dollar limits for any individual on specific covered

5-34 benefits that are not essential health benefits to the extent that such limits are otherwise permitted

6-1 under applicable federal law or the laws and regulations of this state.

6-2 (3) In determining whether an individual has received benefits that meet or exceed the
6-3 allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier and a
6-4 health benefit plan shall take into account only essential health benefits.
6-5 (b) Lifetime limits.
6-6 (1) A health insurance carrier and health benefit plan offering group or individual health
6-7 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
6-8 benefits, as designated pursuant to a state determination and in accordance with federal laws and
6-9 regulations, for any individual.
6-10 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
6-11 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
6-12 benefits that are not essential health benefits, as designated pursuant to a state determination and
6-13 in accordance with federal laws and regulations.
6-14 (c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this
6-15 subsection, this subsection applies to any individual:
6-16 (A) Whose coverage or benefits under a health plan ended by reason of reaching a
6-17 lifetime limit on the dollar value of all benefits for the individual; and
6-18 (B) Who, due to the provisions of this section, becomes eligible, or is required to become
6-19 eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the
6-20 health benefit plan:
6-21 (i) For group health insurance coverage, on the first day of the first plan year beginning
6-22 on or after September 23, 2010; or
6-23 (ii) For individual health insurance coverage, on the first day of the first policy year
6-24 beginning on or after September 23, 2010.
6-25 (2) For individual health insurance coverage, an individual is not entitled to reinstatement
6-26 under the health benefit plan under this subsection if the individual reached his or her lifetime
6-27 limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection
6-28 applies to a family member who reached his or her lifetime limit in a family plan and other family
6-29 members remain covered under the plan.
6-30 (3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to
6-31 become eligible for benefits, the health insurance carrier and health benefit plan shall provide the
6-32 individual written notice that:
6-33 (i) The lifetime limit on the dollar value of all benefits no longer applies; and
7-34 (ii) The individual, if still covered under the plan, is again eligible to receive benefits
7-35 under the plan.
7-36 (B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for,
7-37 but not enrolled in any benefit package under the plan, the health insurance carrier and health
7-38 benefit plan shall provide an opportunity for the individual to enroll in the plan for a period of at
7-39 least thirty (30) days.
7-40 (C) The notices and enrollment opportunity under this subdivision shall be provided
7-41 beginning not later than:
7-42 (i) For group health insurance coverage, the first day of the first plan year beginning on
7-43 or after September 23, 2010;
7-44 (ii) For individual health insurance coverage, the first day of the first policy year
7-45 beginning on or after September 23, 2010; or
7-46 (iii) The notices required under this subsection shall be provided:
7-47 (I) For group health insurance coverage, to an employee on behalf of the employee's
7-48 dependent; or
7-49 (II) For individual health insurance coverage, to the primary subscriber on behalf of the
7-50 primary subscriber's dependent.
7-51 (D) For group health insurance coverage, the notices may be included with other
7-52 enrollment materials that a health plan distributes to employees, provided the statement is
7-53 prominent. For group health insurance coverage, if a notice satisfying the requirements of this
7-54 subsection is provided to an individual, a health insurance carrier's requirement to provide the
7-55 notice with respect to that individual is satisfied.
7-56 (E) For any individual who enrolls in a health plan in accordance with subdivision (2) of

7-57 this subsection, coverage under the plan shall take effect not later than:
7-58 (i) For group health insurance coverage, the first day of the first plan year beginning on
7-59 or after September 23, 2010; or
7-60 (ii) For individual health insurance coverage, the first day of the first policy year
7-61 beginning on or after September 23, 2010.
7-62 (d)(1) An individual enrolling in a health plan for group health insurance coverage in
7-63 accordance with subsection (c) above shall be treated as if the individual were a special enrollee
7-64 as provided under regulations interpreting the HIPAA portability provisions issued pursuant to
7-65 Section 2714 of the Affordable Care Act.
7-66 (2) An individual enrolling in accordance with subsection (c) above:
7-67 (A) Shall be offered all of the benefit packages available to similarly situated individuals
7-68 who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value
8-1 of all benefits; and
8-2 (B) Shall not be required to pay more for coverage than similarly situated individuals
8-3 who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all
8-4 benefits.
8-5 (3) For purposes of subsection (B)(1), any difference in benefits or cost-sharing
8-6 constitutes a different benefit package.
8-7 (e)(1) The provisions of this section relating to lifetime limits apply to any health
8-8 insurance carrier providing coverage under an individual or group health plan, including
8-9 grandfathered health plans.
8-10 (2) The provisions of this section relating to annual limits apply to any health insurance
8-11 carrier providing coverage under a group health plan, including grandfathered health plans, but
8-12 the prohibition and limits on annual limits do not apply to grandfathered health plans providing
8-13 individual health insurance coverage.
8-14 **27-18-80. Coverage for preventive items and services.** – (a) Every health insurance
8-15 carrier providing coverage under an individual or group health plan shall provide coverage for all
8-16 of the following items and services, and shall not impose any cost-sharing requirements, such as a
8-17 copayment, coinsurance or deductible, with respect to the following items and services:
8-18 (1) Except as otherwise provided in subsection (b) of this section, and except as may
8-19 otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-
8-20 based items or services that have in effect a rating of A or B in the recommendations of the
8-21 United States Preventive Services Task Force as of September 23, 2010 and as may subsequently
8-22 be amended.
8-23 (2) Immunizations for routine use in children, adolescents and adults that have in effect a
8-24 recommendation from the Advisory Committee on Immunization Practices of the Centers for
8-25 Disease Control and Prevention with respect to the individual involved. For purposes of this
8-26 subdivision, a recommendation from the Advisory Committee on Immunization Practices of the
8-27 Centers for Disease Control and Prevention is considered in effect after it has been adopted by the
8-28 Director of the Centers for Disease Control and Prevention, and a recommendation is considered
8-29 to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease
8-30 Control and Prevention.
8-31 (3) With respect to infants, children and adolescents, evidence-informed preventive care,
8-32 and screenings provided for in comprehensive guidelines supported by the Health Resources and
8-33 Services Administration.
9-34 (4) With respect to women, to the extent not described in subdivision (1) of this
9-35 subsection, evidence-informed preventive care and screenings provided for in comprehensive
9-36 coverage guidelines supported by the Health Resources and Services Administration.
9-37 (b)(1) A health insurance carrier is not required to provide coverage for any items or
9-38 services specified in any recommendation or guideline described in subsection (a) of this section
9-39 after the recommendation or guideline is no longer described in subsection (a) of this section. The
9-40 provisions of this subdivision shall not affect the obligation of the health insurance carrier to
9-41 provide notice to a covered person before any material modification of coverage becomes
9-42 effective, in accordance with other requirements of state and federal law, including section
9-43 2715(d)(4) of the Public Health Services Act.

9-44 (2) A health insurance carrier shall at least annually at the beginning of each new plan
9-45 year or policy year, whichever is applicable, revise the preventive services covered under its
9-46 health benefit plans pursuant to this section consistent with the recommendations of the United
9-47 States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the
9-48 Centers for Disease Control and Prevention and the guidelines with respect to infants, children,
9-49 adolescents and women evidence-based preventive care and screenings by the Health Resources
9-50 and Services Administration in effect at the time.

9-51 (c)(1) A health insurance carrier may impose cost-sharing requirements with respect to an
9-52 office visit if an item or service described in subsection (a) of this section is billed separately or is
9-53 tracked as individual encounter data separately from the office visit.

9-54 (2) A health insurance carrier shall not impose cost-sharing requirements with respect to
9-55 an office visit if an item or service described in subsection (a) of this section is not billed
9-56 separately or is not tracked as individual encounter data separately from the office visit and the
9-57 primary purpose of the office visit is the delivery of the item or service described in subsection
9-58 (a) of this section.

9-59 (3) A health insurance carrier may impose cost-sharing requirements with respect to an
9-60 office visit if an item or service described in subsection (a) of this section is not billed separately
9-61 or is not tracked as individual encounter data separately from the office visit and the primary
9-62 purpose of the office visit is not the delivery of the item or service.

9-63 (d)(1) Nothing in this section requires a health insurance carrier that has a network of
9-64 providers to providing coverage for items and services described in subsection (a) of this section
9-65 that are delivered by an out-of-network provider.

9-66 (2) Nothing in subsection (a) of this section precludes a health insurance carrier that has a
9-67 network of providers from imposing cost-sharing requirements for items or services described in
9-68 subsection (a) of this section that are delivered by an out-of-network provider.

10-1 (e) Nothing prevents a health insurance carrier from using reasonable medical
10-2 management techniques to determine the frequency, method, treatment or setting for an item or
10-3 service described in subsection (a) of this section to the extent not specified in the
10-4 recommendation or guideline.

10-5 (f) Nothing in this section prohibits a health insurance carrier from providing coverage
10-6 for items and services in addition to those recommended by the United States Preventive Services
10-7 Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease
10-8 Control and Prevention, or provided by guidelines supported by the Health Resources and
10-9 Services Administration, or from denying coverage for items and services that are not
10-10 recommended by that task force or that advisory committee, or under those guidelines. A health
10-11 insurance carrier may impose cost-sharing requirements for a treatment not described in
10-12 subsection (a) of this section even if the treatment results from an item or service described in
10-13 subsection (a) of this section.

10-14 (g) This section shall not apply to grandfathered health plans.

10-15 **27-18-81. Coverage for individuals participating in approved clinical trials.** – (a) As
10-16 used in this section,

10-17 (1) “Approved clinical trial” means a phase I, phase II, phase III or phase IV clinical trial
10-18 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
10-19 threatening disease or condition and is described in any of the following:

10-20 (A) The study or investigation is approved or funded, which may include funding through
10-21 in-kind contributions, by one or more of the following:

10-22 (i) The National Institutes of Health;

10-23 (ii) The Centers for Disease Control and Prevention;

10-24 (iii) The Agency for Health Care Research and Quality;

10-25 (iv) The Centers for Medicare & Medicaid Services;

10-26 (v) A cooperative group or center of any of the entities described in items (i) through (iv)
10-27 or the Department of Defense or the Department of Veteran Affairs;

10-28 (vi) A qualified non-governmental research entity identified in the guidelines issued by
10-29 the National Institutes of Health for center support grants; or

10-30 (vii) A study or investigation conducted by the Department of Veteran Affairs, the

10-31 Department of Defense, or the Department of Energy, if the study or investigation has been
10-32 reviewed and approved through a system of peer review that the Secretary of U.S. Department of
10-33 Health and Human Services determines:

11-34 (I) Is comparable to the system of peer review of studies and investigations used by the
11-35 National Institutes of Health; and

11-36 (II) Assures unbiased review of the highest scientific standards by qualified individuals
11-37 who have no interest in the outcome of the review.

11-38 (B) The study or investigation is conducted under an investigational new drug application
11-39 reviewed by the Food and Drug Administration; or

11-40 (C) The study or investigation is a drug trial that is exempt from having such an
11-41 investigational new drug application.

11-42 (2) “Participant” has the meaning stated in section 3(7) of ERISA.

11-43 (3) “Participating provider” means a health care provider that, under a contract with the
11-44 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
11-45 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
11-46 deductibles, directly or indirectly from the health carrier.

11-47 (4) “Qualified individual” means a participant or beneficiary who meets the following
11-48 conditions:

11-49 (A) The individual is eligible to participate in an approved clinical trial according to the
11-50 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;
11-51 and

11-52 (B)(i) The referring health care professional is a participating provider and has concluded
11-53 that the individual’s participation in such trial would be appropriate based on the individual
11-54 meeting the conditions described in subdivision (A) of this subdivision (3); or

11-55 (ii) The participant or beneficiary provides medical and scientific information
11-56 establishing the individual’s participation in such trial would be appropriate based on the
11-57 individual meeting the conditions described in subdivision (A) of this subdivision (3).

11-58 (5) “Life-threatening condition” means any disease or condition from which the
11-59 likelihood of death is probable unless the course of the disease or condition is interrupted.

11-60 (b)(1) If a health insurance carrier offering group or individual health insurance coverage
11-61 provides coverage to a qualified individual, the health insurance carrier:

11-62 (A) Shall not deny the individual participation in an approved clinical trial.

11-63 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose
11-64 additional conditions on the coverage of routine patient costs for items and services furnished in
11-65 connection with participation in the approved clinical trial; and

11-66 (C) Shall not discriminate against the individual on the basis of the individual’s
11-67 participation in the approved clinical trial.

12-68 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all
12-69 items and services consistent with the coverage typically covered for a qualified individual who is
12-70 not enrolled in an approved clinical trial.

12-71 (B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not
12-72 include:

12-73 (i) The investigational item, device or service itself;

12-74 (ii) Items and services that are provided solely to satisfy data collection and analysis
12-75 needs and that are not used in the direct clinical management of the patient; or

12-76 (iii) A service that is clearly inconsistent with widely accepted and established standards
12-77 of care for a particular diagnosis.

12-78 (3) If one or more participating providers are participating in a clinical trial, nothing in
12-79 subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring
12-80 that a qualified individual participate in the trial through such a participating provider if the
12-81 provider will accept the individual as a participant in the trial.

12-82 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection
12-83 shall apply to a qualified individual participating in an approved clinical trial that is conducted
12-84 outside this state.

12-85 (5) This section shall not be construed to require a health insurance carrier offering group

12-86 or individual health insurance coverage to provide benefits for routine patient care services
12-87 provided outside of the coverage's health care provider network unless out-of-network benefits
12-88 are otherwise provided under the coverage.
12-89 (6) Nothing in this section shall be construed to limit a health insurance carrier's
12-90 coverage with respect to clinical trials.
12-91 (c) The requirements of this section shall be in addition to the requirements of Rhode
12-92 Island general laws sections 27-18-36 through 27-18-36.3.
12-93 (d) This section shall not apply to grandfathered health plans.
12-94 (e) This section shall be effective for plan years beginning on or after January 1, 2014.
12-95 **27-18-82. Medical loss ratio rebates.** – (a) A health insurance carrier offering group or
12-96 individual health insurance coverage, including a grandfathered health plan, shall pay medical
12-97 loss ratio rebates as provided for in Section 2718(b)(1)(A) of the Affordable Care Act, in the
12-98 manner and as required by federal laws and regulations.
12-99 (b) Health insurance carriers required to report medical loss ratio and rebate calculations
12-100 and other medical loss ratio and rebate information to the U.S. Department of Health and Human
12-101 Services shall concurrently file such information with the commissioner.
13-102 **27-18-83. Emergency services.** – (a) As used in this section:
13-103 (1) "Emergency medical condition" means a medical condition manifesting itself by
13-104 acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
13-105 possesses an average knowledge of health and medicine, could reasonably expect the absence of
13-106 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
13-107 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
13-108 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
13-109 part
13-110 (2) "Emergency services" means, with respect to an emergency medical condition:
13-111 (A) A medical screening examination (as required under section 1867 of the Social
13-112 Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a
13-113 hospital, including ancillary services routinely available to the emergency department to evaluate
13-114 such emergency medical condition, and
13-115 (B) Such further medical examination and treatment, to the extent they are within the
13-116 capabilities of the staff and facilities available at the hospital, as are required under section 1867
13-117 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.
13-118 (3) "Stabilize", with respect to an emergency medical condition has the meaning given in
13-119 section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).
13-120 (b) If a health insurance carrier offering health insurance coverage provides any benefits
13-121 with respect to services in an emergency department of a hospital, the carrier must cover
13-122 emergency services in compliance with this section.
13-123 (c) A health insurance carrier shall provide coverage for emergency services in the
13-124 following manner:
13-125 (1) Without the need for any prior authorization determination, even if the emergency
13-126 services are provided on an out-of-network basis;
13-127 (2) Without regard to whether the health care provider furnishing the emergency services
13-128 is a participating network provider with respect to the services;
13-129 (3) If the emergency services are provided out of network, without imposing any
13-130 administrative requirement or limitation on coverage that is more restrictive than the requirements
13-131 or limitations that apply to emergency services received from in-network providers;
13-132 (4) If the emergency services are provided out of network, by complying with the cost-
13-133 sharing requirements of subsection (d) of this section; and
13-134 (5) Without regard to any other term or condition of the coverage, other than:
13-135 (A) The exclusion of or coordination of benefits;
14-136 (B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title
14-137 XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or
14-138 (C) Applicable cost-sharing.
14-139 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
14-140 rate imposed with respect to a participant or beneficiary for out-of-network emergency services

14-141 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
14-142 the services were provided in-network; provided, however, that a participant or beneficiary may
14-143 be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-
14-144 network provider charges over the amount the health insurance carrier is required to pay under
14-145 subdivision (1) of this subsection. A health insurance carrier complies with the requirements of
14-146 this subsection if it provides benefits with respect to an emergency service in an amount equal to
14-147 the greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision
14-148 (1)(which are adjusted for in-network cost-sharing requirements).

14-149 (A) The amount negotiated with in-network providers for the emergency service
14-150 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
14-151 participant or beneficiary. If there is more than one amount negotiated with in-network providers
14-152 for the emergency service, the amount described under this subdivision (A) is the median of these
14-153 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
14-154 participant or beneficiary. In determining the median described in the preceding sentence, the
14-155 amount negotiated with each in-network provider is treated as a separate amount (even if the
14-156 same amount is paid to more than one provider). If there is no per-service amount negotiated with
14-157 in-network providers (such as under a capitation or other similar payment arrangement), the
14-158 amount under this subdivision (A) is disregarded.

14-159 (B) The amount for the emergency service shall be calculated using the same method the
14-160 plan generally uses to determine payments for out-of-network services (such as the usual,
14-161 customary, and reasonable amount), excluding any in-network copayment or coinsurance
14-162 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
14-163 determined without reduction for out-of-network cost-sharing that generally applies under the
14-164 plan or health insurance coverage with respect to out-of-network services.

14-165 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
14-166 Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network
14-167 copayment or coinsurance imposed with respect to the participant or beneficiary.

14-168 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
14-169 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
14-170 services provided out of network if the cost-sharing requirement generally applies to out-of-
15-1 network benefits. A deductible may be imposed with respect to out-of-network emergency
15-2 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
15-3 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
15-4 apply to out-of-network emergency services.

15-5 (e) The provisions of this section apply for plan years beginning on or after September
15-6 23, 2010.

15-7 (f) This section shall not apply to grandfathered health plans.

15-8 **27-18-84. Internal and external appeal of adverse benefit determinations.** – (a) The
15-9 commissioner shall adopt regulations to implement standards and procedures with respect to
15-10 internal claims and appeals of adverse benefit determinations, and with respect to external appeals
15-11 of adverse benefit determinations.

15-12 (b) The regulations adopted by the commissioner shall apply to those adverse benefit
15-13 determinations within the jurisdiction of the commissioner. ^(add)

15-14 SECTION 3. Sections 27-18-8, 27-18-44 and 27-18-59 of the General laws in Chapter
15-15 27-18 entitled "Accident and Sickness Insurance Policies" are hereby amended to read as follows:

15-16 **27-18-8. Filing of accident and sickness insurance policy forms.** -- Any insurance
15-17 company authorized to do an accident and sickness business within this state in accordance with
15-18 the provisions of this title shall file all accident and sickness insurance policy forms and rates
15-19 used by it in the state with the insurance commissioner, including the forms of any rider,
15-20 endorsement, application blank, and other matter generally used or incorporated by reference in
15-21 its policies or contracts of insurance. ^(add) No such rate shall be used unless first approved by the
15-22 commissioner. No such form shall be used if disapproved by the commissioner under this section,
15-23 or if the commissioner's approval has been withdrawn under section 27-18-8.3, or until the
15-24 expiration of the waiting period established under section 27-18-8.3. Such a company shall
15-25 comply with its filed and approved rates and forms. ^(add) If the commissioner finds from an

15-26 examination of any form that it is contrary to the public interest, or the requirements of this code
15-27 or duly promulgated regulations, he or she shall forbid its use, and shall notify the company in
15-28 writing as provided in section 27-18-8.2. Each form shall include a certification by a qualified
15-29 actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance
15-30 with applicable laws and that the benefits are reasonable in relation to the premium to be charged.

15-31 **27-18-44. Primary and preventive obstetric and gynecological care.** – ^{add}(a)^{add} Any insurer
15-32 or ^{add}health plan, ^{add} nonprofit ^{delete}medical^{delete}^{add} medical^{add} service plan ^{add}, or nonprofit hospital
service plan^{add} that

15-33 provides coverage for obstetric and gynecological care for issuance or delivery in the state to any
15-34 group or individual on an expense-incurred basis, including ^{add}a health plan offered or issued by a
16-1 health insurance carrier or^{add} a health maintenance organization, shall permit a woman to receive an
16-2 annual visit to an in-network obstetrician/gynecologist for routine gynecological care without
16-3 requiring the woman to first obtain a referral from a primary care provider.

16-4 ^{add}(b)(1)(A) Any health plan, nonprofit medical service plan or nonprofit hospital service
16-5 plan, including a health insurance carrier or a health maintenance organization which requires or
16-6 provides for the designation by a covered person of a participating primary health care
16-7 professional shall permit each covered person to:

16-8 (i) Designate any participating primary care health care professional who is available to
16-9 accept the covered person; and

16-10 (ii) For a child, designate any participating physician who specializes in pediatrics as the
16-11 child's primary care health care professional and is available to accept the child.

16-12 (2) The provisions of subdivision (1) of this subsection shall not be construed to waive
16-13 any exclusions of coverage under the terms and conditions of the health benefit plan with respect
16-14 to coverage of pediatric care.

16-15 (c)(1) If a health plan, nonprofit medical service plan or nonprofit hospital service plan,
16-16 including a health insurance carrier or a health maintenance organization, provides coverage for
16-17 obstetrical or gynecological care and requires the designation by a covered person of a
16-18 participating primary care health care professional, then it:

16-19 (A) Shall not require any person's, including a primary care health care professional's,
16-20 prior authorization or referral in the case of a female covered person who seeks coverage for
16-21 obstetrical or gynecological care provided by a participating health care professional who
16-22 specializes in obstetrics or gynecology; and

16-23 (B) Shall treat the provision of obstetrical and gynecological care, and the ordering of
16-24 related obstetrical and gynecological items and services, pursuant to subdivision (A) of this
16-25 subdivision (c)(1), by a participating health care professional who specializes in obstetrics or
16-26 gynecology as the authorization of the primary care health care professional.

16-27 (2)(A) A health plan, nonprofit medical service plan or nonprofit hospital service plan,
16-28 including a health insurance carrier or a health maintenance organization may require the health
16-29 care professional to agree to otherwise adhere to its policies and procedures, including procedures
16-30 relating to referrals, obtaining prior authorization, and providing services in accordance with a
16-31 treatment plan, if any, approved by the plan, carrier or health maintenance organization.

16-32 (B) For purposes of subdivision (A) of this subdivision (c)(1), a health care professional,
16-33 who specializes in obstetrics or gynecology, means any individual, including an individual other
16-34 than a physician, who is authorized under state law to provide obstetrical or gynecological care.

17-1 (3) The provisions of subdivision (A) of this subdivision (c)(1) shall not be construed to:

17-2 (A) Waive any exclusions of coverage under the terms and conditions of the health
17-3 benefit plan with respect to coverage of obstetrical or gynecological care; or

17-4 (B) Preclude the health plan, nonprofit medical service plan or nonprofit hospital service
17-5 plan, including a health insurance carrier or a health maintenance organization involved from
17-6 requiring that the participating health care professional providing obstetrical or gynecological
17-7 care notify the primary care health care professional or the plan, carrier or health maintenance
17-8 organization of treatment decisions.

17-9 (d) Notice Requirements:

17-10 (1) A health plan, nonprofit medical service plan or nonprofit hospital service plan,
17-11 including a health insurance carrier or a health maintenance organization subject to this section

17-12 shall provide notice to covered persons of the terms and conditions of the plan related to the
17-13 designation of a participating health care professional and of a covered person's rights with
17-14 respect to those provisions.

17-15 (2)(A) In the case of group health insurance coverage, the notice described in subdivision
17-16 (1) of this subsection shall be included whenever the a participant is provided with a summary
17-17 plan description or other similar description of benefits under the health benefit plan.

17-18 (B) In the case of individual health insurance coverage, the notice described in
17-19 subdivision (1) of this subsection shall be included whenever the primary subscriber is provided
17-20 with a policy, certificate or contract of health insurance.

17-21 (C) A health plan, nonprofit medical service plan or nonprofit hospital service plan,
17-22 including a health insurance carrier or a health maintenance organization, may use the model
17-23 language in 45 CFR section 147.138(a)(4)(iii) to satisfy the requirements of this subsection.

17-24 (e) The requirements of subsections (b), (c), and (d) shall not apply to grandfathered
17-25 health plans. ^{add}

17-26 ~~27-18-59.~~ ^{delete} ~~Termination of children's benefits~~ ^{delete} ^{add} Eligibility for children's benefits ^{add} ~~..~~

17-27 (a) ^{add} (1) ^{add} Every individual health insurance contract, plan, or policy delivered, issued for delivery, or
17-28 renewed in this state and every group health insurance contract, plan, or policy delivered, issued
17-29 for delivery or renewed in this state which provides ^{delete} ~~medical~~ ^{delete} ^{add} health benefits ^{add} coverage for
17-30 ^{delete} ~~dependent children that includes coverage for physician services in a physician's office, and every~~
17-31 ~~policy which provides major medical or similar comprehensive type coverage~~ ^{add} dependents ^{add}, except
17-32 for supplemental policies which only provide coverage for specified diseases and other
17-33 supplemental policies, shall ^{add} provide ^{add} make ^{add} coverage ^{add} available ^{add} ~~of an unmarried child under the~~
17-34 ~~age~~ ~~of nineteen (19) years, an unmarried child who is a student under the age of twenty five (25)~~
18-1 ~~years and who is financially dependent upon the parent and an unmarried child of any age who is~~
18-2 ~~financially dependent upon the parent and medically determined to have a physical or mental~~
18-3 ~~impairment which can be expected to result in death or which has lasted or can be expected to last~~
18-4 ~~for a continuous period of not less than twelve (12) months~~ ^{delete} ^{add} for children until attainment of
18-5 twenty-six (26) years of age ^{add} ^{delete} ~~Such contract, plan or policy shall also include a provision that~~
18-6 ~~policyholders shall receive no less than thirty (30) days notice from the accident and sickness~~
18-7 ~~insurer that a child covered as a dependent by the policy holder is about to lose his or her~~
18-8 ~~coverage as a result of reaching the maximum age for a dependent child, and that the child will~~
18-9 ~~only continue to be covered upon documentation being provided of current full or part-time~~
18-10 ~~enrollment in a post-secondary educational institution or that the child may purchase a conversion~~
18-11 ~~policy if he or she is not an eligible student. Nothing in this section prohibits an accident and~~
18-12 ~~sickness insurer from requiring a policyholder to annually provide proof of a child's current full~~
18-13 ~~or part-time enrollment in a post-secondary educational institution in order to maintain the child's~~
18-14 ~~coverage. Provided, nothing in this section requires coverage inconsistent with the membership~~
18-15 ~~criteria in effect under the policyholder's health benefits coverage.~~ ^{delete}

18-16 ^{add} (2) With respect to a child who has not attained twenty-six (26) years of age, a health
18-17 insurance carrier shall not define "dependent" for purposes of eligibility for dependent coverage
18-18 of children other than the terms of a relationship between a child and the plan participant, and, in
18-19 the individual market, primary subscriber.

18-20 (3) A health insurance carrier shall not deny or restrict coverage for a child who has not
18-21 attained twenty-six (26) years of age based on the presence or absence of the child's financial
18-22 dependency upon the participant, primary subscriber or any other person, residency with the
18-23 participant and in the individual market the primary subscriber, or with any other person, marital
18-24 status, student status, employment or any combination of those factors. A health carrier shall not
18-25 deny or restrict coverage of a child based on eligibility for other coverage, except as provided in
18-26 subparagraph (d)(1) of this section.

18-27 (4) Nothing in this section shall be construed to require a health insurance carrier to make
18-28 coverage available for the child of a child receiving dependent coverage, unless the grandparent
18-29 becomes the legal guardian or adoptive parent of that grandchild.

18-30 (5) The terms of coverage in a health benefit plan offered by a health insurance carrier
18-31 providing dependent coverage of children cannot vary based on age except for children who are

18-32 twenty-six (26) years of age or older.

18-33 (b)(1) This subsection applies to any child:

19-34 (A) Whose coverage ended, or who was denied coverage, or was not eligible for group

19-35 health insurance coverage or individual health insurance coverage under a health benefit plan

19-36 because, under the terms of coverage, the availability of dependent coverage of a child ended

19-37 before the attainment of twenty-six (26) years of age; and

19-38 (B) Who becomes eligible, or is required to become eligible, for coverage on the first day

19-39 of the first plan year and, in the individual market, the first day of the first policy year, beginning

19-40 on or after September 23, 2010 by reason of the provisions of this section.

19-41 (2)(A) If group health insurance coverage or individual health insurance coverage, in

19-42 which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in

19-43 which the child's coverage ended or did not begin for the reasons described in subdivision (1) of

19-44 this subsection, and if the health insurance carrier is subject to the requirements of this section the

19-45 health insurance carrier shall give the child an opportunity to enroll that continues for at least

19-46 sixty (60) days, including the written notice of the opportunity to enroll as described subdivision

19-47 (3) of this subsection.

19-48 (B) The health insurance carrier shall provide the opportunity to enroll, including the

19-49 written notice beginning not later than the first day of the first plan year and in the individual

19-50 market the first day of the first policy year, beginning on or after September 23, 2010.

19-51 (3)(A) The written notice of opportunity to enroll shall include a statement that children

19-52 whose coverage ended, or who were denied coverage, or were not eligible for coverage, because

19-53 the availability of dependent coverage of children ended before the attainment of twenty-six (26)

19-54 years of age are eligible to enroll in the coverage.

19-55 (B)(i) The notice may be provided to an employee on behalf of the employee's child and,

19-56 in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

19-57 (ii) For group health insurance coverage:

19-58 (I)The notice may be included with other enrollment materials that the health carrier

19-59 distributes to employees, provided the statement is prominent; and

19-60 (II) If a notice satisfying the requirements of this subdivision is provided to an employee

19-61 whose child is entitled to an enrollment opportunity under subsection (c) of this section, the

19-62 obligation to provide the notice of enrollment opportunity under subdivision (B) of this

19-63 subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.

19-64 (C) The written notice shall be provided beginning not later than the first day of the first

19-65 plan year and in the individual market the first day of the first policy year, beginning on or after

19-66 September 23, 2010.

19-67 (4) For an individual who enrolls under this subsection, the coverage shall take effect not

19-68 later than the first day of the first plan year and, in the individual market, the first day of the first

20-1 policy year, beginning on or after September 23, 2010.

20-2 (c)(1) A child enrolling in group health insurance coverage pursuant to subsections (b)

20-3 and (c) of this section shall be treated as if the child were a special enrollee, as provided under

20-4 regulations interpreting the Health Insurance Portability and Accountability Act ("HIPAA")

20-5 portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

20-6 (2)(A) The child and, if the child would not be a participant once enrolled, the participant

20-7 through whom the child is otherwise eligible for coverage under the plan, shall be offered all the

20-8 benefit packages available to similarly situated individuals who did not lose coverage by reason

20-9 of cessation of dependent status.

20-10 (B) For purposes of this subdivision (2), any difference in benefits or cost-sharing

20-11 requirements constitutes a different benefit package.

20-12 (3) The child shall not be required to pay more for coverage than similarly situated

20-13 individuals who did not lose coverage by reason of cessation of dependent status.

20-14 (d)(1) For plan years beginning before January 1, 2014, a health insurance carrier

20-15 providing group health insurance coverage that is a grandfathered health plan and makes

20-16 available dependent coverage of children may exclude an adult child who has not attained twenty-

20-17 six (26) years of age from coverage only if the adult child is eligible to enroll in an eligible

20-18 employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal

20-19 Revenue Code, other than the group health plan of a parent.

20-20 (2) For plan years, beginning on or after January 1, 2014, a health insurance carrier

20-21 providing group health insurance coverage that is a grandfathered health plan shall comply with

20-22 the requirements of subsections (a) through (e) of this section.

20-23 (3) The provisions of this section shall apply to policy years in the individual market on

20-24 and after September 23, 2010. ^{add} -

20-25 ~~(b)~~ ^{add} ~~(e)~~ ^{add} This section does not apply to insurance coverage providing benefits for: (1)

20-26 hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5)

20-27 Medicare supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other

20-28 limited benefit policies.

20-29 SECTION 4. Sections 27-19-1 and 27-19-50 of the General laws in Chapter 27-19

20-30 entitled "Nonprofit Hospital Service Corporations" are hereby amended to read as follows:

20-31 **27-19-1. Definitions. --** As used in this chapter:

20-32 (1) "Contracting hospital" means an eligible hospital which has contracted with a

20-33 nonprofit hospital service corporation to render hospital care to subscribers to the nonprofit

20-34 hospital service plan operated by the corporation;

21-1 (2) ^{add} "Adverse benefit determination" means any of the following: a denial, reduction, or

21-2 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,

21-3 including any such denial, reduction, termination, or failure to provide or make payment that is

21-4 based on a determination of a participant's or beneficiary's eligibility to participate in a plan or to

21-5 receive coverage under a plan, and including, with respect to group health plans, a denial,

21-6 reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a

21-7 benefit resulting from the application of any utilization review, as well as a failure to cover an

21-8 item or service for which benefits are otherwise provided because it is determined to be

21-9 experimental or investigational or not medically necessary or appropriate. The term also includes

21-10 a rescission of coverage determination.

21-11 (3) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010,

21-12 as amended by the Health Care and Education Reconciliation Act of 2010.

21-13 (4) "Commissioner" or "health insurance commissioner" means that individual appointed

21-14 pursuant to section 42-14.5-1 of the General laws.

21-15 (5) ^{add} "Eligible hospital" is one which is maintained either by the state or by any of its

21-16 political subdivisions or by a corporation organized for hospital purposes under the laws of this

21-17 state or of any other state or of the United States, which is designated as an eligible hospital by a

21-18 majority of the directors of the nonprofit hospital service corporation;

21-19 ^{add} (6) "Grandfathered health plan" means any group health plan or health insurance

21-20 coverage subject to 42 USC section 18011;

21-21 (7) "Group health insurance coverage" means, in connection with a group health plan,

21-22 health insurance coverage offered in connection with such plan;

21-23 (8) "Group health plan" means an employee welfare benefit plan as defined 29 USC

21-24 section 1002(1), to the extent that the plan provides health benefits to employees or their

21-25 dependents directly or through insurance, reimbursement, or otherwise;

21-26 (9) "Health benefits" or "covered benefits" means medical, surgical, hospital,

21-27 prescription drug, and such other benefits, whether self-funded, or delivered through the purchase

21-28 of insurance or otherwise;

21-29 (10) "Health care facility" means an institution providing health care services or a health

21-30 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory

21-31 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,

21-32 laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

21-33 (11) "Health care professional" means a physician or other health care practitioner

21-34 licensed, accredited or certified to perform specified health care services consistent with state

22-1 law;

22-2 (12) "Health care provider" or "provider" means a health care professional or a health

22-3 care facility;

22-4 (13) "Health care services" means services for the diagnosis, prevention, treatment, cure

22-5 or relief of a health condition, illness, injury or disease;

22-6 (14) "Health insurance carrier" means a person, firm, corporation or other entity subject
22-7 to the jurisdiction of the commissioner under this chapter, and includes nonprofit hospital service
22-8 corporations. Such term does not include a group health plan;
22-9 (15) "Health plan" or "health benefit plan" means health insurance coverage and a group
22-10 health plan, including coverage provided through an association plan if it covers Rhode Island
22-11 residents. Except to the extent specifically provided by the Affordable Care Act, the term "health
22-12 plan" shall not include a group health plan to the extent state regulation of the health plan is pre-
22-13 empted under section 514 of the Employee Retirement Income Security Act of 1974. The term
22-14 also shall not include:
22-15 (A)(i) Coverage only for accident, or disability income insurance, or any combination
22-16 thereof.
22-17 (ii) Coverage issued as a supplement to liability insurance.
22-18 (iii) Liability insurance, including general liability insurance and automobile liability
22-19 insurance.
22-20 (iv) Workers' compensation or similar insurance.
22-21 (v) Automobile medical payment insurance.
22-22 (vi) Credit-only insurance.
22-23 (vii) Coverage for on-site medical clinics.
22-24 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant to
22-25 Pub. L. No. 104-191, the health insurance portability and accountability act of 1996 ("HIPAA"),
22-26 under which benefits for medical care are secondary or incidental to other insurance benefits.
22-27 (B) The following benefits if they are provided under a separate policy, certificate or
22-28 contract of insurance or are otherwise not an integral part of the plan:
22-29 (i) Limited scope dental or vision benefits.
22-30 (ii) Benefits for long-term care, nursing home care, home health care, community-based
22-31 care, or any combination thereof.
22-32 (iii) Other excepted benefits specified in federal regulations issued pursuant to Pub. L. No.
22-33 104-191 ("HIPAA").
23-34 (C) The following benefits if the benefits are provided under a separate policy, certificate
23-35 or contract of insurance, there is no coordination between the provision of the benefits and any
23-36 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the
23-37 benefits are paid with respect to an event without regard to whether benefits are provided with
23-38 respect to such an event under any group health plan maintained by the same plan sponsor:
23-39 (i) Coverage only for a specified disease or illness.
23-40 (ii) Hospital indemnity or other fixed indemnity insurance.
23-41 (D) The following if offered as a separate policy, certificate or contract of insurance:
23-42 (i) Medicare supplement health insurance as defined under section 1882(g)(1) of the
23-43 Social Security Act.
23-44 (ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United
23-45 States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).
23-46 (iii) Similar supplemental coverage provided to coverage under a group health plan.^{add}
23-47 ~~(3)~~^{delete} ~~(3)~~^{delete} ^{add} (16)^{add} "Nonprofit hospital service corporation" means any corporation organized
23-48 pursuant to this chapter for the purpose of establishing, maintaining, and operating a nonprofit
23-49 hospital service plan;
23-50 ~~(4)~~^{delete} ~~(4)~~^{delete} ^{add} (17)^{add} "Nonprofit hospital service plan" means a plan by which specified hospital
23-51 care
23-52 is to be provided to subscribers to the plan by a contracting hospital; ~~and~~^{delete}
23-53 ^{add} (18) "Office of the health insurance commissioner" means the agency established under
23-54 section 42-14.5-1 of the General Law;
23-55 (19) "Rescission" means a cancellation or discontinuance of coverage that has retroactive
23-56 effect for reasons unrelated to timely payment of required premiums or contribution to costs of
23-57 coverage; and^{add}
23-58 ~~(5)~~^{delete} ~~(5)~~^{delete} ^{add} (20)^{add} "Subscribers" mean those persons, whether or not residents of this state, who
23-59 have contracted with a nonprofit hospital service corporation for hospital care pursuant to a
nonprofit hospital service plan operated by the corporation.

23-60 **27-19-50. Termination of children's benefits Eligibility for children's benefits. --** (a)

23-61 ^{add}(1)^{add} Every individual health insurance contract, plan, or policy delivered, issued for delivery, or

23-62 renewed in this state and every group health insurance contract, plan, or policy delivered, issued

23-63 for delivery or renewed in this state which provides ^{delete}medical^{delete} ^{add}health benefits^{add} coverage

23-64 ~~for~~

23-64 ~~dependent children that includes coverage for physician services in a physician's office, and every~~

23-65 ~~policy which provides major medical or similar comprehensive type coverage~~^{delete} ^{add}dependents^{add},

23-66 except

23-66 for supplemental policies which only provide coverage for specified diseases and other

23-67 supplemental policies, shall ~~provide~~ ^{add}make^{add} coverage ^{add}available^{add} ~~of an unmarried child~~

23-68 ~~under the age~~

23-68 ~~of nineteen (19) years, an unmarried child who is a student under the age of twenty five (25)~~

24-1 ~~years and who is financially dependent upon the parent and an unmarried child of any age who is~~

24-2 ~~financially dependent upon the parent and medically determined to have a physical or mental~~

24-3 ~~impairment which can be expected to result in death or which has lasted or can be expected to last~~

24-4 ~~for a continuous period of not less than twelve (12) months~~^{delete} ^{add}for children until attainment of

24-5 ~~twenty-six (26) years of age~~^{add} ^{delete}.^{delete} Such contract, plan or policy shall also include a provision that

24-6 ~~policyholders shall receive no less than thirty (30) days notice from the nonprofit hospital service~~

24-7 ~~corporation that a child covered as a dependent by the policyholder is about to lose his or her~~

24-8 ~~coverage as a result of reaching the maximum age for a dependent child and that the child will~~

24-9 ~~only continue to be covered upon documentation being provided of current full or part time~~

24-10 ~~enrollment in a post secondary educational institution, or that the child may purchase a~~

24-11 ~~conversion policy if he or she is not an eligible student.~~

24-12 ~~(b) Nothing in this section prohibits a nonprofit hospital service corporation from~~

24-13 ~~requiring a policyholder to annually provide proof of a child's current full or part time enrollment~~

24-14 ~~in a post secondary educational institution in order to maintain the child's coverage. Provided,~~

24-15 ~~nothing in this section requires coverage inconsistent with the membership criteria in effect under~~

24-16 ~~the policyholder's health benefits coverage.~~^{delete}

24-17 ^{add}(2) With respect to a child who has not attained twenty-six (26) years of age, a health

24-18 insurance carrier shall not define "dependent" for purposes of eligibility for dependent coverage

24-19 of children other than the terms of a relationship between a child and the plan participant, and, in

24-20 the individual market, primary subscriber.

24-21 (3) A health insurance carrier shall not deny or restrict coverage for a child who has not

24-22 attained twenty-six (26) years of age based on the presence or absence of the child's financial

24-23 dependency upon the participant, primary subscriber or any other person, residency with the

24-24 participant and in the individual market the primary subscriber, or with any other person, marital

24-25 status, student status, employment or any combination of those factors. A health carrier shall not

24-26 deny or restrict coverage of a child based on eligibility for other coverage, except as provided in

24-27 (d)(1) of this section.

24-28 (4) Nothing in this section shall be construed to require a health insurance carrier to make

24-29 coverage available for the child of a child receiving dependent coverage, unless the grandparent

24-30 becomes the legal guardian or adoptive parent of that grandchild.

24-31 (5) The terms of coverage in a health benefit plan offered by a health insurance carrier

24-32 providing dependent coverage of children cannot vary based on age except for children who are

24-33 twenty-six (26) years of age or older.

25-34 (b)(1) This subsection applies to any child:

25-35 (A) Whose coverage ended, or who was denied coverage, or was not eligible for group

25-36 health insurance coverage or individual health insurance coverage under a health benefit plan

25-37 because, under the terms of coverage, the availability of dependent coverage of a child ended

25-38 before the attainment of twenty-six (26) years of age; and

25-39 (B) Who becomes eligible, or is required to become eligible, for coverage on the first day

25-40 of the first plan year and, in the individual market, the first day of the first policy year, beginning

25-41 on or after September 23, 2010 by reason of the provisions of this section.

25-42 (2)(A) If group health insurance coverage or individual health insurance coverage, in

25-43 which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in

25-44 which the child's coverage ended or did not begin for the reasons described in subdivision (1) of
25-45 this subsection, and if the health insurance carrier is subject to the requirements of this section the
25-46 health insurance carrier shall give the child an opportunity to enroll that continues for at least
25-47 sixty (60) days, including the written notice of the opportunity to enroll as described subdivision
25-48 (3) of this subsection.

25-49 (B) The health insurance carrier shall provide the opportunity to enroll, including the
25-50 written notice beginning not later than the first day of the first plan year and in the individual
25-51 market the first day of the first policy year, beginning on or after September 23, 2010.

25-52 (3)(A) The written notice of opportunity to enroll shall include a statement that children
25-53 whose coverage ended, or who were denied coverage, or were not eligible for coverage, because
25-54 the availability of dependent coverage of children ended before the attainment of twenty-six (26)
25-55 years of age are eligible to enroll in the coverage.

25-56 (B)(i) The notice may be provided to an employee on behalf of the employee's child and,
25-57 in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

25-58 (ii) For group health insurance coverage:

25-59 (I) The notice may be included with other enrollment materials that the health carrier
25-60 distributes to employees, provided the statement is prominent; and

25-61 (II) If a notice satisfying the requirements of this subdivision is provided to an employee
25-62 whose child is entitled to an enrollment opportunity under subsection (b) of this section, the
25-63 obligation to provide the notice of enrollment opportunity under subdivision (B) of this
25-64 subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.

25-65 (C) The written notice shall be provided beginning not later than the first day of the first
25-66 plan year and in the individual market the first day of the first policy year, beginning on or after
25-67 September 23, 2010.

26-68 (4) For an individual who enrolls under this subsection, the coverage shall take effect not
26-69 later than the first day of the first plan year and, in the individual market, the first day of the first
26-70 policy year, beginning on or after September 23, 2010.

26-71 (c)(1) A child enrolling in group health insurance coverage pursuant to subsection (b) of
26-72 this section shall be treated as if the child were a special enrollee, as provided under regulations
26-73 interpreting the HIPAA portability provisions issued pursuant to Section 2714 of the Affordable
26-74 Care Act.

26-75 (2)(A) The child and, if the child would not be a participant once enrolled, the participant
26-76 through whom the child is otherwise eligible for coverage under the plan, shall be offered all the
26-77 benefit packages available to similarly situated individuals who did not lose coverage by reason
26-78 of cessation of dependent status.

26-79 (B) For purposes of this subdivision (2), any difference in benefits or cost-sharing
26-80 requirements constitutes a different benefit package.

26-81 (3) The child shall not be required to pay more for coverage than similarly situated
26-82 individuals who did not lose coverage by reason of cessation of dependent status.

26-83 (d)(1) For plan years beginning before January 1, 2014, a group health plan providing
26-84 group health insurance coverage that is a grandfathered health plan and makes available
26-85 dependent coverage of children may exclude an adult child who has not attained twenty-six (26)
26-86 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-
26-87 sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code,
26-88 other than the group health plan of a parent.

26-89 (2) For plan years, beginning on or after January 1, 2014, a group health plan providing
26-90 group health insurance coverage that is a grandfathered health plan shall comply with the
26-91 requirements of subsections (a) through (e).

26-92 (3) The provision of this section applies to policy years in the individual market on and
26-93 after September 23, 2010, and shall apply to grandfathered health plans.

26-94 ~~(b)~~(e) This section does not apply to insurance coverage providing benefits for: (1)
26-95 hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5)
26-96 Medicare supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other
26-97 limited benefit policies.^{add}

26-98 SECTION 5. Chapter 27-19 of the General laws entitled "Nonprofit Hospital Service

26-99 Corporations" is hereby amended by adding thereto the following sections:
26-100 ^(add) **27-19-7.1. Uniform explanation of benefits and coverage.** – (a) A nonprofit hospital
26-101 service corporation shall provide a uniform summary of benefits and coverage explanation and
26-102 standardized definitions to policyholders and others required by, and at the times required by, the
27-1 federal regulations adopted under section 2715 of the Affordable Care Act. A summary required
27-2 by this section shall be filed with the commissioner for approval under Rhode Island general laws
27-3 section 27-19-7.2. The requirements of this section shall be in addition to the requirements of
27-4 Rhode Island general laws section 27-19-7.2. The commissioner may waive one or more of the
27-5 requirements of the regulations adopted under section 2715 of the Affordable Care Act for good
27-6 cause shown. The summary must contain at least the following information:
27-7 (1) Uniform definitions of standard insurance and medical terms.
27-8 (2) A description of coverage and cost-sharing for each category of essential benefits and
27-9 other benefits.
27-10 (3) Exceptions, reductions and limitations in coverage.
27-11 (4) Renewability and continuation of coverage provisions.
27-12 (5) A “coverage facts label” that illustrates coverage under common benefits scenarios.
27-13 (6) A statement of whether the policy, contract or plan provides the minimum coverage
27-14 required of a qualified health plan.
27-15 (7) A statement that the outline is a summary and that the actual policy language should
27-16 be consulted; and
27-17 (8) A contact number for the consumer to call with additional questions and the web
27-18 address of where the actual language of the policy, contract or plan can be found.
27-19 (b) The provisions of this section shall apply to grandfathered health plans.
27-20 **27-19-7.2. Filing of policy forms.** – A nonprofit hospital service corporation shall file all
27-21 policy forms and rates used by it in the state with the commissioner, including the forms of any
27-22 rider, endorsement, application blank, and other matter generally used or incorporated by
27-23 reference in its policies or contracts of insurance. No such rate shall be used unless first approved
27-24 by the commissioner. No such form shall be used if disapproved by the commissioner under this
27-25 section, or if the commissioner's approval has been withdrawn after notice and an opportunity to
27-26 be heard, or until the expiration of sixty (60) days following the filing of the form. A nonprofit
27-27 hospital service corporation shall comply with its filed and approved rates and forms. If the
27-28 commissioner finds from an examination of any form that it is contrary to the public interest, or
27-29 the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and
27-30 shall notify the corporation in writing. Each form shall include a certification by a qualified
27-31 actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance
27-32 with applicable laws and that the benefits are reasonable in relation to the premium to be charged.
27-33 **27-19-62. Prohibition on rescission of coverage.** – (a)(1) Coverage under a health plan
27-34 subject to the jurisdiction of the commissioner under this chapter with respect to an individual,
28-1 including a group to which the individual belongs or family coverage in which the individual is
28-2 included, shall not be rescinded after the individual is covered under the plan, unless:
28-3 (A) The individual or a person seeking coverage on behalf of the individual, performs an
28-4 act, practice or omission that constitutes fraud; or
28-5 (B) The individual makes an intentional misrepresentation of material fact, as prohibited
28-6 by the terms of the plan or coverage.
28-7 (2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an
28-8 individual does not include an insurance producer or employee or authorized representative of the
28-9 health carrier.
28-10 (b) At least thirty (30) days advance written notice shall be provided to each health
28-11 benefit plan enrollee or, for individual health insurance coverage, primary subscriber, who would
28-12 be affected by the proposed rescission of coverage before coverage under the plan may be
28-13 rescinded in accordance with subsection (a) regardless of, in the case of group health insurance
28-14 coverage, whether the rescission applies to the entire group or only to an individual within the
28-15 group.
28-16 (c) For purposes of this section, “to rescind” means to cancel or to discontinue coverage
28-17 with retroactive effect for reasons unrelated to timely payment of required premiums or

28-18 contribution to costs of coverage.
28-19 (d) This section applies to grandfathered health plans.
28-20 **27-19-63. Prohibition on annual and lifetime limits.** – (a) Annual limits. (1) For plan or
28-21 policy years beginning prior to January 1, 2014, for any individual, a health insurance carrier and
28-22 health benefit plan subject to the jurisdiction of the commissioner under this chapter may
28-23 establish an annual limit on the dollar amount of benefits that are essential health benefits
28-24 provided the restricted annual limit is not less than the following:
28-25 (A) For a plan or policy year beginning after September 22, 2010, but before September
28-26 23, 2011 – seven hundred fifty thousand dollars (\$750,000);
28-27 (B) For a plan or policy year beginning after September 22, 2011, but before September
28-28 23, 2012 – one million two hundred fifty thousand dollars (\$1,250,000); and
28-29 (C) For a plan or policy year beginning after September 22, 2012, but before January 1,
28-30 2014 – two million dollars (\$2,000,000).
28-31 (2) For plan or policy years beginning on or after January 1, 2014, a health insurance
28-32 carrier and health benefit plan shall not establish any annual limit on the dollar amount of
28-33 essential health benefits for any individual, except:
29-34 (A) A health flexible spending arrangement, as defined in Section 106(c)(2)(i) of the
29-35 Internal Revenue Code, a medical savings account, as defined in Section 220 of the Internal
29-36 Revenue Code, and a health savings account, as defined in Section 223 of the Internal Revenue
29-37 Code, are not subject to the requirements of subdivisions (1) and (2) of this subsection .
29-38 (B) The provisions of this subsection shall not prevent a health insurance carrier and
29-39 health benefit plan from placing annual dollar limits for any individual on specific covered
29-40 benefits that are not essential health benefits to the extent that such limits are otherwise permitted
29-41 under applicable federal law or the laws and regulations of this state.
29-42 (3) In determining whether an individual has received benefits that meet or exceed the
29-43 allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier and
29-44 health benefit plan shall take into account only essential health benefits.
29-45 (b) Lifetime limits.
29-46 (1) A health insurance carrier and health benefit plan offering group or individual health
29-47 insurance coverage shall not establish a lifetime limit on-the-dollar-value of essential health
29-48 benefits, as designated pursuant to a state determination and in accordance with federal laws and
29-49 regulations, for any individual.
29-50 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
29-51 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
29-52 benefits that are not essential health benefits, as designated pursuant to a state determination and
29-53 in accordance with federal laws and regulations.
29-54 (c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this
29-55 subsection, this subsection applies to any individual:
29-56 (A) Whose coverage or benefits under a health plan ended by reason of reaching a
29-57 lifetime limit on the dollar value of all benefits for the individual; and
29-58 (B) Who, due to the provisions of this section, becomes eligible, or is required to become
29-59 eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the
29-60 health benefit plan:
29-61 (i) For group health insurance coverage, on the first day of the first plan year beginning
29-62 on or after September 23, 2010; or
29-63 (ii) For individual health insurance coverage, on the first day of the first policy year
29-64 beginning on or after September 23, 2010.
29-65 (2) For individual health insurance coverage, an individual is not entitled to reinstatement
29-66 under the health benefit plan under this subsection if the individual reached his or her lifetime
29-67 limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection
29-68 applies to a family member who reached his or her lifetime limit in a family plan and other family
30-1 members remain covered under the plan.
30-2 (3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to
30-3 become eligible for benefits under the health benefit plan, the health carrier shall provide the
30-4 individual written notice that:

30-5 (i) The lifetime limit on the dollar value of all benefits no longer applies; and
30-6 (ii) The individual, if still covered under the plan, is again eligible to receive benefits
30-7 under the plan.
30-8 (B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for,
30-9 but not enrolled in any benefit package under the plan, the health benefit plan shall provide an
30-10 opportunity for the individual to enroll in the plan for a period of at least thirty (30) days.
30-11 (C) The notices and enrollment opportunity under this subdivision shall be provided
30-12 beginning not later:
30-13 (i) For group health insurance coverage, the first day of the first plan year beginning on
30-14 or after September 23, 2010; or
30-15 (ii) For individual health insurance coverage, the first day of the first policy year
30-16 beginning on or after September 23, 2010.
30-17 (iii) The notices required under this subsection shall be provided:
30-18 (I) For group health insurance coverage, to an employee on behalf of the employee's
30-19 dependent; or
30-20 (II) For individual health insurance coverage, to the primary subscriber on behalf of the
30-21 primary subscriber's dependent.
30-22 (D) For group health insurance coverage, the notices may be included with other
30-23 enrollment materials that a health plan distributes to employees, provided the statement is
30-24 prominent. For group health insurance coverage, if a notice satisfying the requirements of this
30-25 subsection is provided to an individual, a health insurance carrier's requirement to provide the
30-26 notice with respect to that individual is satisfied.
30-27 (E) For any individual who enrolls in a health plan in accordance with subdivision (2) of
30-28 this subsection, coverage under the plan shall take effect not later than:
30-29 (i) For group health insurance coverage, the first day of the first plan year beginning on
30-30 or after September 23, 2010; or
30-31 (ii) For individual health insurance coverage, the first day of the first policy year
30-32 beginning on or after September 23, 2010.
30-33 (d)(1) An individual enrolling in a health plan for group health insurance coverage in
30-34 accordance with subsection (c) of this subsection shall be treated as if the individual were a
31-1 special enrollee in the plan, as provided under regulations interpreting the HIPAA portability
31-2 provisions issued pursuant to Section 2714 of the Affordable Care Act.
31-3 (2) An individual enrolling in accordance with subsection (c) of this subsection:
31-4 (A) shall be offered all of the benefit packages available to similarly situated individuals
31-5 who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value
31-6 of all benefits; and
31-7 (B) Shall not be required to pay more for coverage than similarly situated individuals
31-8 who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all
31-9 benefits.
31-10 (3) For purposes of subsection B(1), any difference in benefits or cost-sharing constitutes
31-11 a different benefit package.
31-12 (e)(1) The provisions of this section relating to lifetime limits apply to any health
31-13 insurance carrier providing coverage under an individual or group health plan, including
31-14 grandfathered health plans.
31-15 (2) The provisions of this section relating to annual limits apply to any health insurance
31-16 carrier providing coverage under a group health plan, including grandfathered health plans, but
31-17 the prohibition and limits on annual limits do not apply to grandfathered health plans providing
31-18 individual health insurance coverage.
31-19 **27-19-64. Coverage for preventive items and services.** – (a) Every health insurance
31-20 carrier providing coverage under an individual or group health plan shall provide coverage for all
31-21 of the following items and services, and shall not impose any cost-sharing requirements, such as a
31-22 copayment, coinsurance or deductible, with respect to the following items and services:
31-23 (1) Except as otherwise provided in subsection (b) of this section, and except as may
31-24 otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-
31-25 based items or services that have in effect a rating of A or B in the recommendations of the

31-26 United States Preventive Services Task Force as of September 23, 2010, and as may subsequently
31-27 be amended.

31-28 (2) Immunizations for routine use in children, adolescents and adults that have in effect a
31-29 recommendation from the Advisory Committee on Immunization Practices of the Centers for
31-30 Disease Control and Prevention with respect to the individual involved. For purposes of this
31-31 subdivision, a recommendation from the Advisory Committee on Immunization Practices of the
31-32 Centers for Disease Control and Prevention is considered in effect after it has been adopted by the
31-33 Director of the Centers for Disease Control and Prevention, and a recommendation is considered
31-34 to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease
32-1 Control and Prevention.

32-2 (3) With respect to infants, children and adolescents, evidence-informed preventive care,
32-3 and screenings provided for in comprehensive guidelines supported by the Health Resources and
32-4 Services Administration.

32-5 (4) With respect to women, to the extent not described in subdivision (1) of this
32-6 subsection, evidence-informed preventive care and screenings provided for in comprehensive
32-7 coverage guidelines supported by the Health Resources and Services Administration.

32-8 (b)(1) A health insurance carrier is not required to provide coverage for any items or
32-9 services specified in any recommendation or guideline described in subsection (a) of this section
32-10 after the recommendation or guideline is no longer described in subsection (a) of this section. The
32-11 provisions of this subdivision shall not affect the obligation of the health insurance carrier to
32-12 provide notice to a covered person before any material modification of coverage becomes
32-13 effective, in accordance with other requirements of state and federal law, including section
32-14 2715(d)(4) of the Public Health Services Act.

32-15 (2) A health insurance carrier shall at least annually at the beginning of each new plan
32-16 year or policy year, whichever is applicable, revise the preventive services covered under its
32-17 health benefit plans pursuant to this section consistent with the recommendations of the United
32-18 States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the
32-19 Centers for Disease Control and Prevention and the guidelines with respect to infants, children,
32-20 adolescents and women evidence-based preventive care and screenings by the Health Resources
32-21 and Services Administration in effect at the time.

32-22 (c)(1) A health insurance carrier may impose cost-sharing requirements with respect to an
32-23 office visit if an item or service described in subsection (a) of this section is billed separately or is
32-24 tracked as individual encounter data separately from the office visit.

32-25 (2) A health insurance carrier shall not impose cost-sharing requirements with respect to
32-26 an office visit if an item or service described in subsection (a) of this section is not billed
32-27 separately or is not tracked as individual encounter data separately from the office visit and the
32-28 primary purpose of the office visit is the delivery of the item or service described in subsection
32-29 (a) of this section.

32-30 (3) A health insurance carrier may impose cost-sharing requirements with respect to an
32-31 office visit if an item or service described in subsection (a) of this section is not billed separately
32-32 or is not tracked as individual encounter data separately from the office visit and the primary
32-33 purpose of the office visit is not the delivery of the item or service.

33-34 (d)(1) Nothing in this section requires a health insurance carrier that has a network of
33-35 providers to provide coverage for items and services described in subsection (a) of this section
33-36 that are delivered by an out-of-network provider.

33-37 (2) Nothing in subsection (a) of this section precludes a health insurance carrier that has a
33-38 network of providers from imposing cost-sharing requirements for items or services described in
33-39 subsection (a) of this section that are delivered by an out-of-network provider.

33-40 (e) Nothing prevents a health insurance carrier from using reasonable medical
33-41 management techniques to determine the frequency, method, treatment or setting for an item or
33-42 service described in subsection (a) of this section to the extent not specified in the
33-43 recommendation or guideline.

33-44 (f) Nothing in this section prohibits a health insurance carrier from providing coverage
33-45 for items and services in addition to those recommended by the United States Preventive Services
33-46 Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease

33-47 Control and Prevention, or provided by guidelines supported by the Health Resources and
33-48 Services Administration, or from denying coverage for items and services that are not
33-49 recommended by that task force or that advisory committee, or under those guidelines. A health
33-50 insurance carrier may impose cost-sharing requirements for a treatment not described in
33-51 subsection (a) of this section even if the treatment results from an item or service described in
33-52 subsection (a) of this section.
33-53 (g) This section shall not apply to grandfathered health plans.
33-54 **27-19-65. Coverage for individuals participating in approved clinical trials. – (a) As**
33-55 **used in this section:**
33-56 (1) “Approved clinical trial” means a phase I, phase II, phase III or phase IV clinical trial
33-57 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
33-58 threatening disease or condition and is described in any of the following:
33-59 (A) The study or investigation is approved or funded, which may include funding through
33-60 in-kind contributions, by one or more of the following:
33-61 (i) The National Institutes of Health;
33-62 (ii) The Centers for Disease Control and Prevention;
33-63 (iii) The Agency for Health Care Research and Quality;
33-64 (iv) The Centers for Medicare & Medicaid Services;
33-65 (v) A cooperative group or center of any of the entities described in items (i) through (iv)
33-66 or the Department of Defense or the Department of Veteran Affairs;
33-67 (vi) A qualified non-governmental research entity identified in the guidelines issued by
33-68 the National Institutes of Health for center support grants; or
34-1 (vii) A study or investigation conducted by the Department of Veteran Affairs, the
34-2 Department of Defense, or the Department of Energy, if the study or investigation has been
34-3 reviewed and approved through a system of peer review that the Secretary of U.S. Department of
34-4 Health and Human Services determines:
34-5 (I) Is comparable to the system of peer review of studies and investigations used by the
34-6 National Institutes of Health; and
34-7 (II) Assures unbiased review of the highest scientific standards by qualified individuals
34-8 who have no interest in the outcome of the review.
34-9 (B) The study or investigation is conducted under an investigational new drug application
34-10 reviewed by the Food and Drug Administration; or
34-11 (C) The study or investigation is a drug trial that is exempt from having such an
34-12 investigational new drug application.
34-13 (2) “Participant” has the meaning stated in section 3(7) of ERISA.
34-14 (3) “Participating provider” means a health care provider that, under a contract with the
34-15 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
34-16 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
34-17 deductibles, directly or indirectly from the health carrier.
34-18 (4) “Qualified individual” means a participant or beneficiary who meets the following
34-19 conditions:
34-20 (A) The individual is eligible to participate in an approved clinical trial according to the
34-21 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;
34-22 and
34-23 (B)(i) The referring health care professional is a participating provider and has concluded
34-24 that the individual’s participation in such trial would be appropriate based on the individual
34-25 meeting the conditions described in subdivision (A) of this subdivision (3); or
34-26 (ii) The participant or beneficiary provides medical and scientific information
34-27 establishing the individual’s participation in such trial would be appropriate based on the
34-28 individual meeting the conditions described in subdivision (A) of this subdivision (3).
34-29 (5) “Life-threatening condition” means any disease or condition from which the
34-30 likelihood of death is probable unless the course of the disease or condition is interrupted.
34-31 (b)(1) If a health insurance carrier offering group or individual health insurance coverage
34-32 provides coverage to a qualified individual, the health carrier:
34-33 (A) Shall not deny the individual participation in an approved clinical trial.

35-34 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose
35-35 additional conditions on the coverage of routine patient costs for items and services furnished in
35-36 connection with participation in the approved clinical trial; and
35-37 (C) Shall not discriminate against the individual on the basis of the individual's
35-38 participation in the approved clinical trial.
35-39 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all
35-40 items and services consistent with the coverage typically covered for a qualified individual who is
35-41 not enrolled in an approved clinical trial.
35-42 (B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not
35-43 include:
35-44 (i) The investigational item, device or service itself;
35-45 (ii) Items and services that are provided solely to satisfy data collection and analysis
35-46 needs and that are not used in the direct clinical management of the patient; or
35-47 (iii) A service that is clearly inconsistent with widely accepted and established standards
35-48 of care for a particular diagnosis.
35-49 (3) If one or more participating providers are participating in a clinical trial, nothing in
35-50 subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring
35-51 that a qualified individual participate in the trial through such a participating provider if the
35-52 provider will accept the individual as a participant in the trial.
35-53 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection
35-54 shall apply to a qualified individual participating in an approved clinical trial that is conducted
35-55 outside this state.
35-56 (5) This section shall not be construed to require a health carrier offering group or
35-57 individual health insurance coverage to provide benefits for routine patient care services provided
35-58 outside of the coverage's health care provider network unless out-of-network benefits are
35-59 otherwise provided under the coverage.
35-60 (6) Nothing in this section shall be construed to limit a health carrier's coverage with
35-61 respect to clinical trials.
35-62 (c) The requirements of this section shall be in addition to the requirements of Rhode
35-63 Island general laws sections 27-18-32 through 27-19-32.2.
35-64 (d) This section shall not apply to grandfathered health plans.
35-65 (e) This section shall be effective for plan years beginning on or after January 1, 2014.
35-66 **27-19-66. Medical loss ratio rebates.** – (a) A nonprofit hospital service corporation
35-67 offering group or individual health insurance coverage, including a grandfathered health plan,
35-68 shall pay medical loss ratio rebates as provided for in Section 2718(b)(1)(A) of the Affordable
36-1 Care Act, in the manner and as required by federal laws and regulations.
36-2 (b) Health insurance carriers required to report medical loss ratio and rebate calculations
36-3 and other medical loss ratio and rebate information to the U.S. Department of Health and Human
36-4 Services shall concurrently file such information with the commissioner.
36-5 **27-19-67. Emergency services.** – (a) As used in this section:
36-6 (1) "Emergency medical condition" means a medical condition manifesting itself by
36-7 acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
36-8 possesses an average knowledge of health and medicine, could reasonably expect the absence of
36-9 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
36-10 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
36-11 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
36-12 part.
36-13 (2) "Emergency services" means, with respect to an emergency medical condition:
36-14 (A) A medical screening examination (as required under section 1867 of the Social
36-15 Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a
36-16 hospital, including ancillary services routinely available to the emergency department to evaluate
36-17 such emergency medical condition, and
36-18 (B) Such further medical examination and treatment, to the extent they are within the
36-19 capabilities of the staff and facilities available at the hospital, as are required under section 1867
36-20 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

36-21 (3) “Stabilize”, with respect to an emergency medical condition has the meaning given in
36-22 section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

36-23 (b) If a nonprofit hospital service corporation provides any benefits to subscribers with
36-24 respect to services in an emergency department of a hospital, the plan must cover emergency
36-25 services consistent with the rules of this section.

36-26 (c) A nonprofit hospital service corporation shall provide coverage for emergency
36-27 services in the following manner:

36-28 (1) Without the need for any prior authorization determination, even if the emergency
36-29 services are provided on an out-of-network basis;

36-30 (2) Without regard to whether the health care provider furnishing the emergency services
36-31 is a participating network provider with respect to the services;

36-32 (3) If the emergency services are provided out of network, without imposing any
36-33 administrative requirement or limitation on coverage that is more restrictive than the requirements
36-34 or limitations that apply to emergency services received from in-network providers;

37-1 (4) If the emergency services are provided out of network, by complying with the cost-
37-2 sharing requirements of subsection (d) of this section; and

37-3 (5) Without regard to any other term or condition of the coverage, other than:

37-4 (A) The exclusion of or coordination of benefits;

37-5 (B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title
37-6 XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or

37-7 (C) Applicable cost sharing.

37-8 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
37-9 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
37-10 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
37-11 the services were provided in-network. However, a participant or beneficiary may be required to
37-12 pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network
37-13 provider charges over the amount the plan or health insurance carrier is required to pay under
37-14 subdivision (1) of this subsection. A group health plan or health insurance carrier complies with
37-15 the requirements of this subsection if it provides benefits with respect to an emergency service in
37-16 an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
37-17 this subdivision (1)(which are adjusted for in-network cost-sharing requirements).

37-18 (A) The amount negotiated with in-network providers for the emergency service
37-19 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
37-20 participant or beneficiary. If there is more than one amount negotiated with in-network providers
37-21 for the emergency service, the amount described under this subdivision (A) is the median of these
37-22 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
37-23 participant or beneficiary. In determining the median described in the preceding sentence, the
37-24 amount negotiated with each in-network provider is treated as a separate amount (even if the
37-25 same amount is paid to more than one provider). If there is no per-service amount negotiated with
37-26 in-network providers (such as under a capitation or other similar payment arrangement), the
37-27 amount under this subdivision (A) is disregarded.

37-28 (B) The amount for the emergency service shall be calculated using the same method the
37-29 plan generally uses to determine payments for out-of-network services (such as the usual,
37-30 customary, and reasonable amount), excluding any in-network copayment or coinsurance
37-31 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
37-32 determined without reduction for out-of-network cost sharing that generally applies under the
37-33 plan or health insurance coverage with respect to out-of-network services. Thus, for example, if a
37-34 plan generally pays seventy percent (70%) of the usual, customary, and reasonable amount for
38-1 out-of-network services, the amount in this subdivision (B) for an emergency service is the total,
38-2 that is, one hundred percent (100%), of the usual, customary, and reasonable amount for the
38-3 service, not reduced by the thirty percent (30%) coinsurance that would generally apply to out-of-
38-4 network services (but reduced by the in-network copayment or coinsurance that the individual
38-5 would be responsible for if the emergency service had been provided in-network).

38-6 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
38-7 Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network

38-8 copayment or coinsurance imposed with respect to the participant or beneficiary.
38-9 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
38-10 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
38-11 services provided out of network if the cost-sharing requirement generally applies to out-of-
38-12 network benefits. A deductible may be imposed with respect to out-of-network emergency
38-13 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
38-14 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
38-15 apply to out-of-network emergency services.
38-16 (e) The provisions of this section apply for plan years beginning on or after September
38-17 23, 2010.
38-18 (f) This section shall not apply to grandfathered health plans.
38-19 **27-19-68. Internal and external appeal of adverse benefit determinations.** – (a) The
38-20 commissioner shall adopt regulations to implement standards and procedures with respect to
38-21 internal claims and appeals of adverse benefit determinations, and with respect to external appeals
38-22 of adverse benefit determinations.
38-23 (b) The regulations adopted by the commissioner shall apply to those adverse benefit
38-24 determinations within the jurisdiction of the commissioner.^(add)
38-25 SECTION 6. Sections 27-20-1 and 27-20-45 of the General laws in Chapter 27-20
38-26 entitled "Nonprofit Medical Service Corporations" are hereby amended to read as follows:
38-27 **27-20-1. Definitions.** -- As used in this chapter:
38-28 ^(add)(1) "Adverse benefit determination" means any of the following: a denial, reduction, or
38-29 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,
38-30 including any such denial, reduction, termination, or failure to provide or make payment that is
38-31 based on a determination of a participant's or beneficiary's eligibility to participate in a plan or to
38-32 receive coverage under a plan, and including, with respect to group health plans, a denial,
38-33 reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a
38-34 benefit resulting from the application of any utilization review, as well as a failure to cover an
39-1 item or service for which benefits are otherwise provided because it is determined to be
39-2 experimental or investigational or not medically necessary or appropriate. The term also includes
39-3 a rescission of coverage determination.
39-4 (2) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010,
39-5 as amended by the Health Care and Education Reconciliation Act of 2010.^(add)
39-6 ~~(4)~~^(delete) ~~(3)~~^(add) "Certified registered nurse practitioners" is an expanded role utilizing
independent
39-7 knowledge of physical assessment and management of health care and illnesses. The practice
39-8 includes collaboration with other licensed health care professionals including, but not limited to,
39-9 physicians, pharmacists, podiatrists, dentists, and nurses;
39-10 ^(add)(4) "Commissioner" or "health insurance commissioner" means that individual appointed
39-11 pursuant to section 42-14.5-1 of the General laws.
39-12 ~~(2)~~(5) "Counselor in mental health" means a person who has been licensed pursuant to
39-13 section 5-63.2-9.
39-14 (6) "Grandfathered health plan" means any group health plan or health insurance
39-15 coverage subject to 42 USC section 18011.
39-16 (7) "Group health insurance coverage" means, in connection with a group health plan,
39-17 health insurance coverage offered in connection with such plan.
39-18 (8) "Group health plan" means an employee welfare benefit plan as defined in 29 USC
39-19 section 1002(1) to the extent that the plan provides health benefits to employees or their
39-20 dependents directly or through insurance, reimbursement, or otherwise.
39-21 (9) "Health benefits" or "covered benefits" means medical, surgical, hospital,
39-22 prescription drug, and such other benefits, whether self-funded, or delivered through the purchase
39-23 of insurance or otherwise.
39-24 (10) "Health care facility" means an institution providing health care services or a health
39-25 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory
39-26 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,
39-27 laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

41-49 in any nonprofit medical service plan. Medical service shall not be construed to include hospital
41-50 services;
41-51 ~~(5)~~ ⁽¹⁸⁾ "Nonprofit medical service corporation" means any corporation organized
41-52 pursuant hereto for the purpose of establishing, maintaining, and operating a nonprofit medical
41-53 service plan;
41-54 ~~(6)~~ ⁽¹⁹⁾ "Nonprofit medical service plan" means a plan by which specified medical
41-55 service is provided to subscribers to the plan by a nonprofit medical service corporation;
41-56 ⁽²⁰⁾ "Office of the health insurance commissioner" means the agency established under
41-57 section 42-14.5-1 of the General laws.
41-58 ~~(7)~~ ⁽²¹⁾ "Psychiatric and mental health nurse clinical specialist" is an expanded role
41-59 utilizing independent knowledge and management of mental health and illnesses. The practice
41-60 includes collaboration with other licensed health care professionals, including, but not limited to,
41-61 psychiatrists, psychologists, physicians, pharmacists, and nurses;
41-62 ⁽²²⁾ "Rescission" means a cancellation or discontinuance of coverage that has retroactive
41-63 effect for reasons unrelated to timely payment of required premiums or contribution to costs of
41-64 coverage.
41-65 ~~(8)~~ ⁽²³⁾ "Subscribers" means those persons or groups of persons who contract with a
41-66 nonprofit medical service corporation for medical service pursuant to a nonprofit medical service
41-67 plan; and
42-68 ~~(9)~~ ⁽²⁴⁾ "Therapist in marriage and family practice" means a person who has been
42-69 licensed pursuant to section 5-63.2-10.
42-70 27-20-45. Termination of children's benefits. ~~Eligibility for children's benefits.~~ --

(a)

42-71 Every individual health insurance contract, plan, or policy delivered, issued for delivery, or
42-72 renewed in this state and every group health insurance contract, plan, or policy delivered, issued
42-73 for delivery or renewed in this state which provides ~~medical~~ ^{health benefits} coverage for
42-74 ~~dependent children that includes coverage for physician services in a physician's office, and every~~
42-75 ~~policy which provides major medical or similar comprehensive type coverage dependents,~~ except
42-76 for supplemental policies which only provide coverage for specified diseases and other
42-77 supplemental policies, shall ~~provide~~ ^{make} coverage ^{available} ~~of an~~
42-78 ~~unmarried child under the age~~
42-79 ~~of nineteen (19) years, an unmarried child who is a student under the age of twenty five (25)~~
42-80 ~~years and who is financially dependent upon the parent and an unmarried child of any age who is~~
42-81 ~~financially dependent upon the parent and medically determined to have a physical or mental~~
42-82 ~~impairment which can be expected to result in death or which has lasted or can be expected to last~~
42-83 ~~for a continuous period of not less than twelve (12) months~~ ^{for children until attainment of}
42-84 ~~twenty-six (26) years of age.~~ ^{Such contract, plan or policy shall also include a provision that}
42-85 ~~policyholders shall receive no less than thirty (30) days notice from the nonprofit medical service~~
42-86 ~~corporation that a child covered as a dependent by the policyholder is about to lose his or her~~
42-87 ~~coverage as a result of reaching the maximum age for a dependent child and that the child will~~
42-88 ~~only continue to be covered upon documentation being provided of current full or part-time~~
42-89 ~~enrollment in a post-secondary educational institution, or that the child may purchase a~~
42-90 ~~conversion policy if he or she is not an eligible student.~~

42-91 ~~(b) Nothing in this section prohibits a nonprofit medical service corporation from~~
42-92 ~~requiring a policyholder to annually provide proof of a child's current full or part-time enrollment~~
42-93 ~~in a post-secondary educational institution in order to maintain the child's coverage. Provided,~~
42-94 ~~nothing in this section requires coverage inconsistent with the membership criteria in effect under~~
42-95 ~~the policyholder's health benefits coverage.~~

42-96 ⁽²⁾ With respect to a child who has not attained twenty-six (26) years of age, a nonprofit
42-97 medical service corporation shall not define "dependent" for purposes of eligibility for dependent
42-98 coverage of children other than the terms of a relationship between a child and the plan
42-99 participant, and, in the individual market, primary subscriber.

42-100 (3) A nonprofit medical service corporation shall not deny or restrict coverage for a child
42-101 who has not attained twenty-six (26) years of age based on the presence or absence of the child's
financial dependency upon the participant, primary subscriber or any other person, residency with

42-102 the participant and in the individual market the primary subscriber, or with any other person,
43-1 marital status, student status, employment or any combination of those factors. A nonprofit
43-2 medical service corporation shall not deny or restrict coverage of a child based on eligibility for
43-3 other coverage, except as provided in (d)(1) of this section.
43-4 (4) Nothing in this section shall be construed to require a health insurance carrier to make
43-5 coverage available for the child of a child receiving dependent coverage, unless the grandparent
43-6 becomes the legal guardian or adoptive parent of that grandchild.
43-7 (5) The terms of coverage in a health benefit plan offered by a nonprofit medical service
43-8 corporation r providing dependent coverage of children cannot vary based on age except for
43-9 children who are twenty-six (26) years of age or older.
43-10 (b)(1) This subsection applies to any child:
43-11 (A) Whose coverage ended, or who was denied coverage, or was not eligible for group
43-12 health insurance coverage or individual health insurance coverage under a health benefit plan
43-13 because, under the terms of coverage, the availability of dependent coverage of a child ended
43-14 before the attainment of twenty-six (26) years of age; and
43-15 (B) Who becomes eligible, or is required to become eligible, for coverage on the first day
43-16 of the first plan year and, in the individual market, the first day of the first policy year, beginning
43-17 on or after September 23, 2010 by reason of the provisions of this section.
43-18 (2)(A) If group health insurance coverage or individual health insurance coverage, in
43-19 which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in
43-20 which the child's coverage ended or did not begin for the reasons described in subdivision (1) of
43-21 this subsection, and if the health insurance carrier is subject to the requirements of this section the
43-22 health insurance carrier shall give the child an opportunity to enroll that continues for at least
43-23 sixty (60) days, including the written notice of the opportunity to enroll as described subdivision
43-24 (3) of this subsection.
43-25 (B) The health insurance carrier shall provide the opportunity to enroll, including the
43-26 written notice beginning not later than the first day of the first plan year and in the individual
43-27 market the first day of the first policy year, beginning on or after September 23, 2010.
43-28 (3)(A) The written notice of opportunity to enroll shall include a statement that children
43-29 whose coverage ended, or who were denied coverage, or were not eligible for coverage, because
43-30 the availability of dependent coverage of children ended before the attainment of twenty-six (26)
43-31 years of age are eligible to enroll in the coverage.
43-32 (B)(i) The notice may be provided to an employee on behalf of the employee's child and,
43-33 in the individual market, to the primary subscriber on behalf of the primary subscriber's child.
44-34 (ii) For group health insurance coverage:
44-35 (I)The notice may be included with other enrollment materials that the health carrier
44-36 distributes to employees, provided the statement is prominent; and
44-37 (II) If a notice satisfying the requirements of this subdivision is provided to an employee
44-38 whose child is entitled to an enrollment opportunity under subsection (c) of this section, the
44-39 obligation to provide the notice of enrollment opportunity under subdivision (B) of this
44-40 subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.
44-41 (C) The written notice shall be provided beginning not later than the first day of the first
44-42 plan year and in the individual market the first day of the first policy year, beginning on or after
44-43 September 23, 2010.
44-44 (4) For an individual who enrolls under this subsection, the coverage shall take effect not
44-45 later than the first day of the first plan year and, in the individual market, the first day of the first
44-46 policy year, beginning on or after September 23, 2010.
44-47 (c)(1) A child enrolling in group health insurance coverage pursuant to subsection (b) of
44-48 this section shall be treated as if the child were a special enrollee, as provided under regulations
44-49 interpreting the HIPAA portability provisions issued pursuant to Section 2714 of the Affordable
44-50 Care Act.
44-51 (2)(A) The child and, if the child would not be a participant once enrolled, the participant
44-52 through whom the child is otherwise eligible for coverage under the plan, shall be offered all the
44-53 benefit packages available to similarly situated individuals who did not lose coverage by reason
44-54 of cessation of dependent status.

44-55 (B) For purposes of this subdivision (2), any difference in benefits or cost-sharing
44-56 requirements constitutes a different benefit package.

44-57 (3) The child shall not be required to pay more for coverage than similarly situated
44-58 individuals who did not lose coverage by reason of cessation of dependent status.

44-59 (d)(1) For plan years beginning before January 1, 2014, a group health plan providing
44-60 group health insurance coverage that is a grandfathered health plan and makes available
44-61 dependent coverage of children may exclude an adult child who has not attained twenty-six (26)
44-62 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-
44-63 sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code,
44-64 other than the group health plan of a parent.

44-65 (2) For plan years, beginning on or after January 1, 2014, a group health plan providing
44-66 group health insurance coverage that is a grandfathered health plan shall comply with the
44-67 requirements of subsections (a) through (e).

45-68 (3) The provisions of this section apply to policy years in the individual market on and
45-69 after September 23, 2010.

45-70 (~~b~~)(e) This section does not apply to insurance coverage providing benefits for: (1)
45-71 hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5)
45-72 Medicare supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other
45-73 limited benefit policies.^(add)

45-74 SECTION 7. Chapter 27-20 of the General laws entitled "Nonprofit Medical Service
45-75 Corporations" is hereby amended by adding thereto the following sections:
45-76 ^(add)**27-20-6.1. Uniform explanation of benefits and coverage.** – (a) A nonprofit medical
45-77 service corporation shall provide a uniform summary of benefits and coverage explanation and
45-78 standardized definitions to policyholders and others required by, and at the times required by the
45-79 federal regulations adopted under section 2715 of the Affordable Care Act. The summary
45-80 required by this section shall be filed with the commissioner for approval under Rhode Island
45-81 general laws section 27-20-6.2. The requirements of this section shall be in addition to the
45-82 requirements of Rhode Island general laws section 27-20-6.2. The commissioner may waive one
45-83 or more of the requirements of the regulations adopted under section 2715 of the Affordable Care
45-84 Act for good cause shown. The summary must contain at least the following information:
45-85 (1) Uniform definitions of standard insurance and medical terms.
45-86 (2) A description of coverage and cost sharing for each category of essential benefits and
45-87 other benefits.
45-88 (3) Exceptions, reductions and limitations in coverage.
45-89 (4) Renewability and continuation of coverage provisions.
45-90 (5) A “coverage facts label” that illustrates coverage under common benefits scenarios.
45-91 (6) A statement of whether the policy, contract or plan provides the minimum coverage
45-92 required of a qualified health plan.
45-93 (7) A statement that the outline is a summary and that the actual policy language should
45-94 be consulted; and
45-95 (8) A contact number for the consumer to call with additional questions and the web
45-96 address of where the actual language of the policy, contract or plan can be found.
45-97 (b) The provisions of this section shall apply to grandfathered health plans.

45-98 **27-20-6.2. Filing of policy forms.** – A nonprofit medical service corporation shall file all
45-99 policy forms and rates used by it in the state with the commissioner, including the forms of any
45-100 rider, endorsement, application blank, and other matter generally used or incorporated by
45-101 reference in its policies or contracts of insurance. No such rate shall be used unless first approved
45-102 by the commissioner. No such form shall be used if disapproved by the commissioner under this
46-1 section, or if the commissioner's approval has been withdrawn after notice and an opportunity to
46-2 be heard, or until the expiration of sixty (60) days following the filing of the form. A nonprofit
46-3 medical service corporation shall comply with its filed and approved rates and forms. If the
46-4 commissioner finds from an examination of any form that it is contrary to the public interest, or
46-5 the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and
46-6 shall notify the corporation in writing. Each form shall include a certification by a qualified
46-7 actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance

46-8 with applicable laws and that the benefits are reasonable in relation to the premium to be charged.
46-9 **27-20-62. Prohibition on rescission of coverage.** – (a)(1) Coverage under a health
46-10 benefit plan subject to the jurisdiction of the commissioner under this chapter with respect to an
46-11 individual, including a group to which the individual belongs or family coverage in which the
46-12 individual is included, shall not be subject to rescission after the individual is covered under the
46-13 plan, unless:
46-14 (A)The individual or a person seeking coverage on behalf of the individual, performs an
46-15 act, practice or omission that constitutes fraud; or
46-16 (B)The individual makes an intentional misrepresentation of material fact, as prohibited
46-17 by the terms of the plan or coverage.
46-18 (2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an
46-19 individual does not include an insurance producer or employee or authorized representative of the
46-20 health carrier.
46-21 (b) At least thirty (30) days advance written notice shall be provided to each plan enrollee
46-22 or, for individual health insurance coverage, primary subscriber, who would be affected by the
46-23 proposed rescission of coverage before coverage under the plan may be rescinded in accordance
46-24 with subsection (a) regardless of, in the case of group health insurance coverage, whether the
46-25 rescission applies to the entire group or only to an individual within the group.
46-26 (d) This section applies to grandfathered health plans.
46-27 **27-20-63. Annual and lifetime limits.** – (a) Annual limits.
46-28 (1) For plan or policy years beginning prior to January 1, 2014, for any individual, a
46-29 health insurance carrier and health benefit plan subject to the jurisdiction of the commissioner
46-30 under this chapter may establish an annual limit on the dollar amount of benefits that are essential
46-31 health benefits provided the restricted annual limit is not less than the following:
46-32 (A) For a plan or policy year beginning after September 22, 2010, but before September
46-33 23, 2011 – seven hundred fifty thousand dollars (\$750,000);
47-34 (B) For a plan or policy year beginning after September 22, 2011, but before September
47-35 23, 2012 – one million two hundred fifty thousand dollars (\$1,250,000); and
47-36 (C) For a plan or policy year beginning after September 22, 2012, but before January 1,
47-37 2014 – two million dollars (\$2,000,000).
47-38 (2) For plan or policy years beginning on or after January 1, 2014, a health insurance
47-39 carrier and health benefit plan shall not establish any annual limit on the dollar amount of
47-40 essential health benefits for any individual, except:
47-41 (A) A health flexible spending arrangement, as defined in section 106(c)(2)(i) of the
47-42 Internal Revenue Code, a medical savings account, as defined in section 220 of the Internal
47-43 Revenue Code, and a health savings account, as defined in section 223 of the Internal Revenue
47-44 Code are not subject to the requirements of subdivisions (1) and (2) of this subsection.
47-45 (B) The provisions of this subsection shall not prevent a health insurance carrier from
47-46 placing annual dollar limits for any individual on specific covered benefits that are not essential
47-47 health benefits to the extent that such limits are otherwise permitted under applicable federal law
47-48 or the laws and regulations of this state.
47-49 (3) In determining whether an individual has received benefits that meet or exceed the
47-50 allowable limits, as provided in subdivision (1) of this subsection, a health insurance carrier shall
47-51 take into account only essential health benefits as administratively established by the
47-52 commissioner.
47-53 (b) Lifetime limits.
47-54 (1) A health insurance carrier and health benefit plan offering group or individual health
47-55 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
47-56 benefits, as designated pursuant to a state determination and in accordance with federal laws and
47-57 regulations, for any individual.
47-58 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
47-59 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
47-60 benefits that are not essential health benefits, as designated pursuant to a state determination and
47-61 in accordance with federal laws and regulations.
47-62 (c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this

47-63 subsection, this subsection applies to any individual:
47-64 (A) Whose coverage or benefits under a health plan ended by reason of reaching a
47-65 lifetime limit on the dollar value of all benefits for the individual; and
47-66 (B) Who, due to the provisions of this section, becomes eligible, or is required to become
47-67 eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the
47-68 health benefit plan:
48-1 (i) For group health insurance coverage, on the first day of the first plan year beginning
48-2 on or after September 23, 2010; or
48-3 (ii) For individual health insurance coverage, on the first day of the first policy year
48-4 beginning on or after September 23, 2010.
48-5 (2) For individual health insurance coverage, an individual is not entitled to reinstatement
48-6 under the health benefit plan under this subsection if the individual reached his or her lifetime
48-7 limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection
48-8 applies to a family member who reached his or her lifetime limit in a family plan and other family
48-9 members remain covered under the plan.
48-10 (3)(A) If an individual described in subdivision (1) is eligible for benefits or is required to
48-11 become eligible for benefits under the health benefit plan, the health carrier shall provide the
48-12 individual written notice that:
48-13 (i) The lifetime limit on the dollar value of all benefits no longer applies; and
48-14 (ii) The individual, if still covered under the plan, is again eligible to receive benefits
48-15 under the plan.
48-16 (B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for,
48-17 but not enrolled in any benefit package under the plan, the health benefit plan shall provide an
48-18 opportunity for the individual to enroll in the plan for a period of at least thirty (30) days.
48-19 (C) The notices and enrollment opportunity under this subdivision shall be provided
48-20 beginning not later than:
48-21 (i) For group health insurance coverage, the first day of the first plan year beginning on
48-22 or after September 23, 2010; or
48-23 (ii) For individual health insurance coverage, the first day of the first policy year
48-24 beginning on or after September 23, 2010.
48-25 (iii) The notices required under this subsection shall be provided:
48-26 (I) For group health insurance coverage, to an employee on behalf of the employee's
48-27 dependent; or
48-28 (II) For individual health insurance coverage, to the primary subscriber on behalf of the
48-29 primary subscriber's dependent.
48-30 (D) For group health insurance coverage, the notices may be included with other
48-31 enrollment materials that a health plan distributes to employees, provided the statement is
48-32 prominent. For group health insurance coverage, if a notice satisfying the requirements of this
48-33 subsection is provided to an individual, a health insurance carrier's requirement to provide the
48-34 notice with respect to that individual is satisfied.
49-1 (E) For any individual who enrolls in a health plan in accordance with subdivision (2) of
49-2 this subsection, coverage under the plan shall take effect not later than:
49-3 (i) For group health insurance coverage, the first day of the first plan year beginning on
49-4 or after September 23, 2010; or
49-5 (ii) For individual health insurance coverage, the first day of the first policy year
49-6 beginning on or after September 23, 2010.
49-7 (d)(1) An individual enrolling in a health plan for group health insurance coverage in
49-8 accordance with subsection (c) above shall be treated as if the individual were a special enrollee,
49-9 as provided under regulations interpreting the Health Insurance Portability and Accountability
49-10 Act ("HIPAA") portability provisions issued pursuant to Section 2714 of the Affordable Care
49-11 Act.
49-12 (2) An individual enrolling in accordance with subsection (c) above:
49-13 (A) shall be offered all of the benefit packages available to similarly situated individuals
49-14 who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value
49-15 of all benefits; and

49-16 (B) shall not be required to pay more for coverage than similarly situated individuals who
49-17 did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.
49-18 (3) For purposes of subsection B(1), any difference in benefits or cost-sharing constitutes
49-19 a different benefit package.
49-20 (e)(1) Except as provided in subdivision (2) of this subsection, this section applies to any
49-21 health insurance carrier providing coverage under an individual or group health plan.
49-22 (2)(A) The prohibition on lifetime limits applies to grandfathered health plans.
49-23 (B) The prohibition and limits on annual limits apply to grandfathered health plans
49-24 providing group health insurance coverage, but the prohibition and limits on annual limits do not
49-25 apply to grandfathered health plans providing individual health insurance coverage.
49-26 **27-20-64. Coverage for preventive items and services.** – (a) Every health insurance
49-27 carrier providing coverage under an individual or group health plan shall provide coverage for all
49-28 of the following items and services, and shall not impose any cost-sharing requirements, such as a
49-29 copayment, coinsurance or deductible, with respect to the following items and services:
49-30 (1) Except as otherwise provided in subsection (b) of this section, and except as may
49-31 otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-
49-32 based items or services that have in effect a rating of A or B in the recommendations of the
49-33 United States preventive services task force as of September 23, 201 and as may subsequently be
49-34 amended.
50-1 (2) Immunizations for routine use in children, adolescents and adults that have in effect a
50-2 recommendation from the Advisory Committee on Immunization Practices of the Centers for
50-3 Disease Control and Prevention with respect to the individual involved. For purposes of this
50-4 subdivision, a recommendation from the Advisory Committee on Immunization Practices of the
50-5 Centers for Disease Control and Prevention is considered in effect after it has been adopted by the
50-6 Director of the Centers for Disease Control and Prevention, and a recommendation is considered
50-7 to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease
50-8 Control and Prevention.
50-9 (3) With respect to infants, children and adolescents, evidence-informed preventive care,
50-10 and screenings provided for in comprehensive guidelines supported by the Health Resources and
50-11 Services Administration.
50-12 (4) With respect to women, to the extent not described in subdivision (1) of this
50-13 subsection, evidence-informed preventive care and screenings provided for in comprehensive
50-14 coverage guidelines supported by the Health Resources and Services Administration.
50-15 (b)(1) A health insurance carrier is not required to provide coverage for any items or
50-16 services specified in any recommendation or guideline described in subsection (a) of this section
50-17 after the recommendation or guideline is no longer described in subsection (a) of this section. The
50-18 provisions of this subdivision shall not affect the obligation of the health insurance carrier to
50-19 provide notice to a covered person before any material modification of coverage becomes
50-20 effective, in accordance with other requirements of state and federal law, including section
50-21 2715(d)(4) of the Public Health Services Act.
50-22 (2) A health insurance carrier shall at least annually at the beginning of each new plan
50-23 year or policy year, whichever is applicable, revise the preventive services covered under its
50-24 health benefit plans pursuant to this section consistent with the recommendations of the United
50-25 States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the
50-26 Centers for Disease Control and Prevention and the guidelines with respect to infants, children,
50-27 adolescents and women evidence-based preventive care and screenings by the Health Resources
50-28 and Services Administration in effect at the time.
50-29 (c)(1) A health insurance carrier may impose cost-sharing requirements with respect to an
50-30 office visit if an item or service described in subsection (a) of this section is billed separately or is
50-31 tracked as individual encounter data separately from the office visit.
50-32 (2) A health insurance carrier shall not impose cost-sharing requirements with respect to
50-33 an office visit if an item or service described in subsection (a) of this section is not billed
50-34 separately or is not tracked as individual encounter data separately from the office visit and the
51-1 primary purpose of the office visit is the delivery of the item or service described in subsection
51-2 (a) of this section.

51-3 (3) A health insurance carrier may impose cost-sharing requirements with respect to an
51-4 office visit if an item or service described in subsection (a) of this section is not billed separately
51-5 or is not tracked as individual encounter data separately from the office visit and the primary
51-6 purpose of the office visit is not the delivery of the item or service.

51-7 (d)(1) Nothing in this section requires a health insurance carrier that has a network of
51-8 providers to providing coverage for items and services described in subsection (a) of this section
51-9 that are delivered by an out-of-network provider.

51-10 (2) Nothing in subsection (a) of this section precludes a health insurance carrier that has a
51-11 network of providers from imposing cost-sharing requirements for items or services described in
51-12 subsection (a) of this section that are delivered by an out-of-network provider.

51-13 (e) Nothing prevents a health insurance carrier from using reasonable medical
51-14 management techniques to determine the frequency, method, treatment or setting for an item or
51-15 service described in subsection (a) of this section to the extent not specified in the
51-16 recommendation or guideline.

51-17 (f) Nothing in this section prohibits a health insurance carrier from providing coverage
51-18 for items and services in addition to those recommended by the United States Preventive Services
51-19 Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease
51-20 Control and Prevention, or provided by guidelines supported by the Health Resources and
51-21 Services Administration, or from denying coverage for items and services that are not
51-22 recommended by that task force or that advisory committee, or under those guidelines. A health
51-23 insurance carrier may impose cost-sharing requirements for a treatment not described in
51-24 subsection (a) of this section even if the treatment results from an item or service described in
51-25 subsection (a) of this section.

51-26 (g) This section shall not apply to grandfathered health plans.

51-27 **27-20-65. Coverage for individuals participating in approved clinical trials.** – (a) As
51-28 used in this section,

51-29 (1) “Approved clinical trial” means a phase I, phase II, phase III or phase IV clinical trial
51-30 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
51-31 threatening disease or condition and is described in any of the following:

51-32 (A) The study or investigation is approved or funded, which may include funding through
51-33 in-kind contributions, by one or more of the following:

52-34 (i) The National Institutes of Health;

52-35 (ii) The Centers for Disease Control and Prevention;

52-36 (iii) The Agency for Health Care Research and Quality;

52-37 (iv) The Centers for Medicare & Medicaid Services;

52-38 (v) A cooperative group or center of any of the entities described in items (i) through (iv)
52-39 or the Department of Defense or the Department of Veteran Affairs;

52-40 (vi) A qualified non-governmental research entity identified in the guidelines issued by
52-41 the National Institutes of Health for center support grants; or

52-42 (vii) A study or investigation conducted by the Department of Veteran Affairs, the
52-43 Department of Defense, or the Department of Energy, if the study or investigation has been
52-44 reviewed and approved through a system of peer review that the Secretary of U.S. Department of
52-45 Health and Human Services determines:

52-46 (I) Is comparable to the system of peer review of studies and investigations used by the
52-47 National Institutes of Health; and

52-48 (II) Assures unbiased review of the highest scientific standards by qualified individuals
52-49 who have no interest in the outcome of the review.

52-50 (B) The study or investigation is conducted under an investigational new drug application
52-51 reviewed by the Food and Drug Administration; or

52-52 (C) The study or investigation is a drug trial that is exempt from having such an
52-53 investigational new drug application.

52-54 (2) “Participant” has the meaning stated in section 3(7) of ERISA.

52-55 (3) “Participating provider” means a health care provider that, under a contract with the
52-56 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
52-57 covered persons with an expectation of receiving payment, other than coinsurance, copayments or

52-58 deductibles, directly or indirectly from the health carrier.

52-59 (4) “Qualified individual” means a participant or beneficiary who meets the following

52-60 conditions:

52-61 (A) The individual is eligible to participate in an approved clinical trial according to the

52-62 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;

52-63 and

52-64 (B)(i) The referring health care professional is a participating provider and has concluded

52-65 that the individual’s participation in such trial would be appropriate based on the individual

52-66 meeting the conditions described in subdivision (A) of this subdivision (3); or

52-67 (ii) The participant or beneficiary provides medical and scientific information

52-68 establishing the individual’s participation in such trial would be appropriate based on the

53-1 individual meeting the conditions described in subdivision (A) of this subdivision (3).

53-2 (5) “Life-threatening condition” means any disease or condition from which the

53-3 likelihood of death is probable unless the course of the disease or condition is interrupted.

53-4 (b)(1) If a health insurance carrier offering group or individual health insurance coverage

53-5 provides coverage to a qualified individual, the health carrier:

53-6 (A) Shall not deny the individual participation in an approved clinical trial.

53-7 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose

53-8 additional conditions on the coverage of routine patient costs for items and services furnished in

53-9 connection with participation in the clinical approved trial; and

53-10 (C) Shall not discriminate against the individual on the basis of the individual’s

53-11 participation in the clinical trial.

53-12 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all

53-13 items and services consistent with the coverage typically covered for a qualified individual who is

53-14 not enrolled in an approved clinical trial.

53-15 (B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not

53-16 include:

53-17 (i) The investigational item, device or service itself;

53-18 (ii) Items and services that are provided solely to satisfy data collection and analysis

53-19 needs and that are not used in the direct clinical management of the patient; or

53-20 (iii) A service that is clearly inconsistent with widely accepted and established standards

53-21 of care for a particular diagnosis.

53-22 (3) If one or more participating providers is participating in a clinical trial, nothing in

53-23 subdivision (1) of this subsection shall be construed as preventing a health carrier from requiring

53-24 that a qualified individual participate in the trial through such a participating provider if the

53-25 provider will accept the individual as a participant in the trial.

53-26 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection

53-27 shall apply to a qualified individual participating in an approved clinical trial that is conducted

53-28 outside this state.

53-29 (5) This section shall not be construed to require a nonprofit medical service corporation

53-30 offering group or individual health insurance coverage to provide benefits for routine patient care

53-31 services provided outside of the coverage’s health care provider network unless out-of-network

53-32 benefits are otherwise provided under the coverage.

53-33 (6) Nothing in this section shall be construed to limit a health insurance carrier’s

53-34 coverage with respect to clinical trials.

54-1 (c) The requirements of this section shall be in addition to the requirements of Rhode

54-2 Island general laws sections 27-18-36 through 27-18-36.3.

54-3 (d) This section shall not apply to grandfathered health plans.

54-4 (e) This section shall be effective for plan years beginning on or after January 1, 2014.

54-5 **27-20-66. Medical loss ratio rebates.** – (a) A nonprofit medical service corporation

54-6 offering group or individual health insurance coverage, including a grandfathered health plan,

54-7 shall pay medical loss ratio rebates as provided for in Section 2718(b)(1)(A) of the Affordable

54-8 Care Act, in the manner and as required by federal laws and regulations.

54-9 (b) Nonprofit medical service corporations required to report medical loss ratio and

54-10 rebate calculations and any other medical loss ratio and rebate information to the U.S.

54-11 Department of Health and Human Services shall concurrently file such information with the
54-12 commissioner.

54-13 **27-20-67. Emergency services --** (a) As used in this section:

54-14 (1) “Emergency medical condition” means a medical condition manifesting itself by
54-15 acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
54-16 possesses an average knowledge of health and medicine, could reasonably expect the absence of
54-17 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
54-18 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
54-19 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
54-20 part

54-21 (2) “Emergency services” means, with respect to an emergency medical condition:

54-22 (A) A medical screening examination (as required under section 1867 of the Social
54-23 Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a
54-24 hospital, including ancillary services routinely available to the emergency department to evaluate
54-25 such emergency medical condition, and

54-26 (B) Such further medical examination and treatment, to the extent they are within the
54-27 capabilities of the staff and facilities available at the hospital, as are required under section 1867
54-28 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

54-29 (3) “Stabilize”, with respect to an emergency medical condition has the meaning given in
54-30 section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

54-31 (b) If a nonprofit medical service corporation offering health insurance coverage provides
54-32 any benefits with respect to services in an emergency department of a hospital, it must cover
54-33 emergency services consistent with the rules of this section.

55-34 (c) A nonprofit medical service corporation shall provide coverage for emergency
55-35 services in the following manner:

55-36 (1) Without the need for any prior authorization determination, even if the emergency
55-37 services are provided on an out-of-network basis;

55-38 (2) Without regard to whether the health care provider furnishing the emergency services
55-39 is a participating network provider with respect to the services;

55-40 (3) If the emergency services are provided out of network, without imposing any
55-41 administrative requirement or limitation on coverage that is more restrictive than the requirements
55-42 or limitations that apply to emergency services received from in-network providers;

55-43 (4) If the emergency services are provided out of network, by complying with the cost-
55-44 sharing requirements of subsection (d) of this section; and

55-45 (5) Without regard to any other term or condition of the coverage, other than:

55-46 (A) The exclusion of or coordination of benefits;

55-47 (B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title
55-48 XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or

55-49 (C) Applicable cost-sharing.

55-50 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
55-51 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
55-52 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
55-53 the services were provided in-network. However, a participant or beneficiary may be required to
55-54 pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network
55-55 provider charges over the amount the plan or health insurance carrier is required to pay under
55-56 subdivision (1) of this subsection. A group health plan or health insurance carrier complies with
55-57 the requirements of this subsection if it provides benefits with respect to an emergency service in
55-58 an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
55-59 this subdivision (1)(which are adjusted for in-network cost-sharing requirements).

55-60 (A) The amount negotiated with in-network providers for the emergency service
55-61 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
55-62 participant or beneficiary. If there is more than one amount negotiated with in-network providers
55-63 for the emergency service, the amount described under this subdivision (A) is the median of these
55-64 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
55-65 participant or beneficiary. In determining the median described in the preceding sentence, the

55-66 amount negotiated with each in-network provider is treated as a separate amount (even if the
55-67 same amount is paid to more than one provider). If there is no per-service amount negotiated with
55-68 in-network providers (such as under a capitation or other similar payment arrangement), the
56-1 amount under this subdivision (A) is disregarded.

56-2 (B) The amount for the emergency service shall be calculated using the same method the
56-3 plan generally uses to determine payments for out-of-network services (such as the usual,
56-4 customary, and reasonable amount), excluding any in-network copayment or coinsurance
56-5 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
56-6 determined without reduction for out-of-network cost-sharing that generally applies under the
56-7 plan or health insurance coverage with respect to out-of-network services.

56-8 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
56-9 Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network
56-10 copayment or coinsurance imposed with respect to the participant or beneficiary.

56-11 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
56-12 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
56-13 services provided out of network if the cost-sharing requirement generally applies to out-of-
56-14 network benefits. A deductible may be imposed with respect to out-of-network emergency
56-15 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
56-16 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
56-17 apply to out-of-network emergency services.

56-18 (e) The provisions of this section apply for plan years beginning on or after September
56-19 23, 2010.

56-20 (f) This section shall not apply to grandfathered health plans.

56-21 **27-20-68. Internal and external appeal of adverse benefit determinations.** -- (a) The
56-22 commissioner shall adopt regulations to implement standards and procedures with respect to
56-23 internal claims and appeals of adverse benefit determinations, and with respect to external appeals
56-24 of adverse benefit determinations.

56-25 (b) The regulations adopted by the commissioner shall apply to those adverse benefit
56-26 determinations within the jurisdiction of the commissioner.^{add}

56-27 SECTION 8. Sections 27-41-2 and 27-41-61 of the General laws in Chapter 27-41
56-28 entitled "Health Maintenance Organizations" are hereby amended to read as follows:

56-29 **27-41-2. Definitions.** – ^{add} As used in this chapter:

56-30 (a) Adverse benefit determination" means any of the following: a denial, reduction, or
56-31 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,
56-32 including any such denial, reduction, termination, or failure to provide or make payment that is
56-33 based on a determination of a participant's or beneficiary's eligibility to participate in a plan or to
56-34 receive coverage under a plan, and including, with respect to group health plans, a denial,
57-1 reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a
57-2 benefit resulting from the application of any utilization review, as well as a failure to cover an
57-3 item or service for which benefits are otherwise provided because it is determined to be
57-4 experimental or investigational or not medically necessary or appropriate. The term also includes
57-5 a rescission of coverage determination.

57-6 (b) "Affordable Care Act" means the Patient Protection and Affordable Care act of 2010,
57-7 as amended by the Health Care and Education Reconciliation Act of 2010.

57-8 (c) "Commissioner" or "health insurance commissioner" means that individual appointed
57-9 pursuant to section 42-14.5-1 of the general laws.^{add}

57-10 ~~{delete}~~ ~~{delete}~~ ~~{delete}~~ ^{add} ~~{delete}~~ ^{add} (d) "Covered health services" means the services that a health maintenance
57-11 organization contracts with enrollees and enrolled groups to provide or make available to an
57-12 enrolled participant.

57-13 ~~{delete}~~ ~~{delete}~~ ~~{delete}~~ ^{add} ~~{delete}~~ ^{add} (e) "Director" means the director of the department of business regulation or his or
her

57-14 duly appointed agents.

57-15 ~~{delete}~~ ~~{delete}~~ ~~{delete}~~ ^{add} ~~{delete}~~ ^{add} (f) "Employee" means any person who has entered into the employment of or
works

57-16 under a contract of service or apprenticeship with any employer. It shall not include a person who

57-17 has been employed for less than thirty (30) days by his or her employer, nor shall it include a
57-18 person who works less than an average of thirty (30) hours per week. For the purposes of this
57-19 chapter, the term "employee" means a person employed by an "employer" as defined in
57-20 Subsection (d) of this section. Except as otherwise provided in this chapter the terms "employee"
57-21 and "employer" are to be defined according to the rules and regulations of the department of labor
57-22 and training.

57-23 ~~(d)~~ ^(g) **"Employer" means any person, partnership, association, trust, estate, or**
57-24 corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy,
57-25 receiver, or trustee of a receiver, or the legal representative of a deceased person, including the
57-26 state of Rhode Island and each city and town in the state, which has in its employ one or more
57-27 individuals during any calendar year. For the purposes of this section, the term "employer" refers
57-28 only to an employer with persons employed within the state of Rhode Island.

57-29 ~~(e)~~ ^(h) "Enrollee" means an individual who has been enrolled in a health maintenance
57-30 organization.

57-31 ~~(f)~~ ⁽ⁱ⁾ "Evidence of coverage" means any certificate, agreement, or contract issued to
an
57-32 enrollee setting out the coverage to which the enrollee is entitled.

57-33 ^(j) "Grandfathered health plan" means any group health plan or health insurance coverage
57-34 subject to 42 USC section 18011.

58-1 (k) "Group health insurance coverage" means, in connection with a group health plan,
58-2 health insurance coverage offered in connection with such plan.

58-3 (l) "Group health plan" means an employee welfare benefit plan as defined in 29 USC
58-4 section 1002(1), to the extent that the plan provides health benefits to employees or their
58-5 dependents directly or through insurance, reimbursement, or otherwise.

58-6 (m) "Health benefits" or "covered benefits" means medical, surgical, hospital,
58-7 prescription drug, and such other benefits, whether self-funded, or delivered through the purchase
58-8 of insurance or otherwise.

58-9 (n) "Health care facility" means an institution providing health care services or a health
58-10 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory
58-11 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,
58-12 laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

58-13 (o) "Health care professional" means a physician or other health care practitioner
58-14 licensed, accredited or certified to perform specified health care services consistent with state
58-15 law.

58-16 (p) "Health care provider" or "provider" means a health care professional or a health care
58-17 facility. ^(add)

58-18 ~~(g)~~ ^(q) "Health care services" means any services included in the furnishing to any
58-19 individual of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of
58-20 that care or hospitalization, and the furnishing to any person of any and all other services for the
58-21 purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

58-22 ^(r) "Health insurance carrier" means a person, firm, corporation or other entity subject to
58-23 the jurisdiction of the commissioner under this chapter, and includes a health maintenance
58-24 organization. Such term does not include a group health plan. ^(add)

58-25 ~~(h)~~ ^(s) "Health maintenance organization" means a single public or private organization
58-26 which:

58-27 (1) Provides or makes available to enrolled participants health care services, including at
58-28 least the following basic health care services: usual physician services, hospitalization, laboratory,
58-29 x-ray, emergency, and preventive services, and out of area coverage, and the services of licensed
58-30 midwives;

58-31 (2) Is compensated, except for copayments, for the provision of the basic health care
58-32 services listed in subdivision (1) of this subsection to enrolled participants on a predetermined
58-33 periodic rate basis; and

59-34 (3) Provides physicians' services primarily:

59-35 (A) Directly through physicians who are either employees or partners of the organization;

59-36 or

60-88 ~~[delete] Such contract, plan or policy shall also include a provision that policyholders shall receive no less~~
60-89 ~~than thirty (30) days notice from the health maintenance organization that a child is about to lose~~
60-90 ~~his or her coverage as a result of reaching the maximum age for a dependent child and that the~~
60-91 ~~child will only continue to be covered upon documentation being provided of current full or part-~~
60-92 ~~time enrollment in a post-secondary educational institution, or that the child may purchase a~~
60-93 ~~conversion policy if he or she is not an eligible student.~~

60-94 ~~(b) Nothing in this section prohibits a nonprofit health maintenance organization from~~
60-95 ~~requiring a policyholder to annually provide proof of a child's current full or part-time enrollment~~
60-96 ~~in a post-secondary educational institution in order to maintain the child's coverage. Provided,~~
60-97 ~~nothing in this section requires coverage inconsistent with the membership criteria in effect under~~
60-98 ~~the policyholder's health benefits coverage.~~ ~~[delete]~~

60-99 ^(add) (2) With respect to a child who has not attained twenty-six (26) years of age, a health
60-100 maintenance organization shall not define "dependent" for purposes of eligibility for dependent
60-101 coverage of children other than the terms of a relationship between a child and the plan
60-102 participant, and, in the individual market, primary subscriber.

61-1 (3) A health maintenance organization shall not deny or restrict coverage for a child who
61-2 has not attained twenty-six (26) years of age based on the presence or absence of the child's
61-3 financial dependency upon the participant, primary subscriber or any other person, residency with
61-4 the participant and in the individual market the primary subscriber, or with any other person,
61-5 marital status, student status, employment or any combination of those factors. A health carrier
61-6 shall not deny or restrict coverage of a child based on eligibility for other coverage, except as
61-7 provided in (d)(1) of this section.

61-8 (4) Nothing in this section shall be construed to require a health maintenance
61-9 organization to make coverage available for the child of a child receiving dependent coverage,
61-10 unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

61-11 (5) The terms of coverage in a health benefit plan offered by a health maintenance
61-12 organization providing dependent coverage of children cannot vary based on age except for
61-13 children who are twenty-six (26) years of age or older.

61-14 (b)(1) This subsection applies to any child:

61-15 (A) Whose coverage ended, or who was denied coverage, or was not eligible for group
61-16 health insurance coverage or individual health insurance coverage under a health benefit plan
61-17 because, under the terms of coverage, the availability of dependent coverage of a child ended
61-18 before the attainment of twenty-six (26) years of age; and

61-19 (B) Who becomes eligible, or is required to become eligible, for coverage on the first day
61-20 of the first plan year and, in the individual market, the first day of the first policy year, beginning
61-21 on or after September 23, 2010 by reason of the provisions of this section.

61-22 (2)(A) If group health insurance coverage or individual health insurance coverage, in
61-23 which a child is eligible to enroll, or is required to become eligible to enroll, in the coverage in
61-24 which the child's coverage ended or did not begin for the reasons described in subdivision (1) of
61-25 this subsection, and if the health insurance carrier is subject to the requirements of this section the
61-26 health insurance carrier shall give the child an opportunity to enroll that continues for at least 60
61-27 days, including the written notice of the opportunity to enroll as described subdivision (3) of this
61-28 subsection.

61-29 (B) The health insurance carrier shall provide the opportunity to enroll, including the
61-30 written notice beginning not later than the first day of the first plan year and in the individual
61-31 market the first day of the first policy year, beginning on or after September 23, 2010.

61-32 (3)(A) The written notice of opportunity to enroll shall include a statement that children
61-33 whose coverage ended, or who were denied coverage, or were not eligible for coverage, because
61-34 the availability of dependent coverage of children ended before the attainment of twenty-six (26)
62-1 years of age are eligible to enroll in the coverage.

62-2 (B)(i) The notice may be provided to an employee on behalf of the employee's child and,
62-3 in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

62-4 (ii) For group health insurance coverage:

62-5 (I) The notice may be included with other enrollment materials that the health carrier
62-6 distributes to employees, provided the statement is prominent; and

62-7 (II) If a notice satisfying the requirements of this subdivision is provided to an employee
62-8 whose child is entitled to an enrollment opportunity under subsection (c) of this section, the
62-9 obligation to provide the notice of enrollment opportunity under subdivision (B) of this
62-10 subdivision (3) with respect to that child is satisfied for both the plan and health insurance carrier.

62-11 (C) The written notice shall be provided beginning not later than the first day of the first
62-12 plan year and in the individual market the first day of the first policy year, beginning on or after
62-13 September 23, 2010.

62-14 (4) For an individual who enrolls under this subsection, the coverage shall take effect not
62-15 later than the first day of the first plan year and, in the individual market, the first day of the first
62-16 policy year, beginning on or after September 23, 2010.

62-17 (c)(1) A child enrolling in group health insurance coverage pursuant to subsection (b) of
62-18 this section shall be treated as if the child were a special enrollee, as provided under regulations
62-19 interpreting the HIPAA portability provisions issued pursuant to section 2714 of the Affordable
62-20 Care.

62-21 (2)(A) The child and, if the child would not be a participant once enrolled, the participant
62-22 through whom the child is otherwise eligible for coverage under the plan, shall be offered all the
62-23 benefit packages available to similarly situated individuals who did not lose coverage by reason
62-24 of cessation of dependent status.

62-25 (B) For purposes of this subdivision (2), any difference in benefits or cost-sharing
62-26 requirements constitutes a different benefit package.

62-27 (3) The child shall not be required to pay more for coverage than similarly situated
62-28 individuals who did not lose coverage by reason of cessation of dependent status.

62-29 (d)(1) For plan years beginning before January 1, 2014, a group health plan providing
62-30 group health insurance coverage that is a grandfathered health plan and makes available
62-31 dependent coverage of children may exclude an adult child who has not attained twenty-six (26)
62-32 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-
62-33 sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code,
62-34 other than the group health plan of a parent.

63-1 (2) For plan years, beginning on or after January 1, 2014, a group health plan providing
63-2 group health insurance coverage that is a grandfathered health plan shall comply with the
63-3 requirements of subsections (a) through (e).

63-4 (3) The provisions of this section apply to policy years in the individual market on and
63-5 after September 23, 2010. ^{add}

63-6 ~~{delete}~~ ~~(b)~~ ~~{delete}~~ ^{add} (e) This section does not apply to insurance coverage providing benefits for: (1)
63-7 hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5)
63-8 Medicare supplement; (6) limited benefit health; (7) specified diseased indemnity; or (8) other
63-9 limited benefit policies. ^{add}

63-10 **SECTION 9.** Chapter 27-41 of the General laws entitled "Health Maintenance
63-11 Organizations" is hereby amended by adding thereto the following sections:

63-12 ^{add} **27-41-29.1. Uniform explanation of benefits and coverage.** -- (a) A health maintenance
63-13 organization shall provide a uniform summary of benefits and coverage explanation and
63-14 standardized definitions to policyholders and others required by, and at the times required by, the
63-15 federal regulations adopted under section 2715 of the Affordable Care Act. A summary required
63-16 by this section shall be filed with the commissioner for approval under Rhode Island general laws
63-17 section 27-41-29.2. The requirements of this section shall be in addition to any other requirements
63-18 imposed as conditions of approval under Rhode Island general laws sections 27-41-29.2. The
63-19 commissioner may waive one or more of the requirements of the regulations adopted under
63-20 section 2715 of the Affordable Care Act for good cause shown. The summary must contain at
63-21 least the following information:

63-22 (1) Uniform definitions of insurance and medical terms.

63-23 (2) A description of coverage and cost-sharing for each category of essential benefits and
63-24 other benefits.

63-25 (3) Exceptions, reductions and limitations in coverage.

63-26 (4) Renewability and continuation of coverage provisions.

63-27 (5) A "coverage facts label" that illustrates coverage under common benefits scenarios.

63-28 (6) A statement of whether the policy, contract or plan provides the minimum coverage
63-29 required of a qualified health plan.

63-30 (7) A statement that the outline is a summary and that the actual policy language should
63-31 be consulted; and

63-32 (8) A contact number for the consumer to call with additional questions and the web
63-33 address of where the actual language of the policy, contract or plan can be found.

64-34 (b) The provisions of this section shall apply to grandfathered health plans.

64-35 **27-41-29.2. Filing of policy forms. --** A health maintenance organization shall file all
64-36 policy forms and rates used by it in the state with the commissioner, including the forms of any
64-37 rider, endorsement, application blank, and other matter generally used or incorporated by
64-38 reference in its policies or contracts of insurance. No such rate shall be used unless first approved
64-39 by the commissioner. No such form shall be used if disapproved by the commissioner under this
64-40 section, or if the commissioner's approval has been withdrawn after notice and an opportunity to
64-41 be heard, or until the expiration of sixty (60) days following the filing of the form. A health
64-42 maintenance organization shall comply with its filed and approved rates and forms. If the
64-43 commissioner finds from an examination of any form that it is contrary to the public interest or
64-44 the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and
64-45 shall notify the corporation in writing. Each form shall include a certification by a qualified
64-46 actuary that to the best of the actuary's knowledge and judgment, the entire rate is in compliance
64-47 with applicable laws and that the benefits are reasonable in relation to the premium to be charged.

64-48 **27-41-75. Prohibition on rescission of coverage. --** (a)(1) Coverage under a health plan
64-49 subject to the jurisdiction of the commissioner under this chapter with respect to an individual,
64-50 including a group to which the individual belongs or family coverage in which the individual is
64-51 included, shall not be rescinded after the individual is covered under the plan, unless:

64-52 (A) The individual or a person seeking coverage on behalf of the individual, performs an
64-53 act, practice or omission that constitutes fraud; or

64-54 (B) The individual makes an intentional misrepresentation of material fact, as prohibited
64-55 by the terms of the plan or coverage.

64-56 (2) For purposes of paragraph (1)(A), a person seeking coverage on behalf of an
64-57 individual does not include an insurance producer or employee or authorized representative of the
64-58 health maintenance organization.

64-59 (b) At least thirty (30) days advance written notice shall be provided to each plan enrollee
64-60 or, for individual health insurance coverage, primary subscriber, who would be affected by the
64-61 proposed rescission of coverage before coverage under the plan may be rescinded in accordance
64-62 with subsection (a) regardless of, in the case of group health insurance coverage, whether the
64-63 rescission applies to the entire group or only to an individual within the group.

64-64 (c) For purposes of this section, "to rescind" means to cancel or to discontinue coverage
64-65 with retroactive effect for reasons unrelated to timely payment of required premiums or
64-66 contribution to costs of coverage.

64-67 (d) This section applies to grandfathered health plans.

65-68 **27-41-76. Prohibition on annual and lifetime limits. --** (a) Annual limits.

65-69 (1) For plan or policy years beginning prior to January 1, 2014, for any individual, a
65-70 health maintenance organization subject to the jurisdiction of the commissioner under this chapter
65-71 may establish an annual limit on the dollar amount of benefits that are essential health benefits
65-72 provided the restricted annual limit is not less than the following:

65-73 (A) For a plan or policy year beginning after September 22, 2010, but before September
65-74 23, 2011 – seven hundred fifty thousand dollars (\$750,000);

65-75 (B) For a plan or policy year beginning after September 22, 2011, but before September
65-76 23, 2012 – one million two hundred fifty thousand dollars (\$1,250,000); and

65-77 (C) For a plan or policy year beginning after September 22, 2012, but before January 1,
65-78 2014 – two million dollars (\$2,000,000).

65-79 (2) For plan or policy years beginning on or after January 1, 2014, a health maintenance
65-80 organization shall not establish any annual limit on the dollar amount of essential health benefits
65-81 for any individual, except:

65-82 (A) A health flexible spending arrangement, as defined in section 106(c)(2)(i) of the

65-83 Internal Revenue Code, a medical savings account, as defined in section 220 of the Internal
65-84 Revenue Code, and a health savings account, as defined in section 223 of the Internal Revenue
65-85 Code are not subject to the requirements of subdivisions (1) and (2) of this subsection .
65-86 (B) The provisions of this subsection shall not prevent a health maintenance organization
65-87 from placing annual dollar limits for any individual on specific covered benefits that are not
65-88 essential health benefits to the extent that such limits are otherwise permitted under applicable
65-89 federal law or the laws and regulations of this state.
65-90 (3) In determining whether an individual has received benefits that meet or exceed the
65-91 allowable limits, as provided in subdivision (1) of this subsection, a health maintenance
65-92 organization shall take into account only essential health benefits as administratively established
65-93 by the commissioner.
65-94 (b) Lifetime limits.
65-95 (1) A health insurance carrier and health benefit plan offering group or individual health
65-96 insurance coverage shall not establish a lifetime limit on the dollar value of essential health
65-97 benefits, as designated pursuant to a state determination and in accordance with federal laws and
65-98 regulations, for any individual.
65-99 (2) Notwithstanding subdivision (1) above, a health insurance carrier and health benefit
65-100 plan is not prohibited from placing lifetime dollar limits for any individual on specific covered
65-101 benefits that are not essential health benefits, as designated pursuant to a state determination and
65-102 in accordance with federal laws and regulations.
66-1 (c)(1) Reinstatement of Coverage. Except as provided in subdivision (2) of this
66-2 subsection, this subsection applies to any individual:
66-3 (A) Whose coverage or benefits under a health plan ended by reason of reaching a
66-4 lifetime limit on the dollar value of all benefits for the individual; and
66-5 (B) Who, due to the provisions of this section, becomes eligible, or is required to become
66-6 eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the
66-7 health benefit plan:
66-8 (i) For group health insurance coverage, on the first day of the first plan year beginning
66-9 on or after September 23, 2010; or
66-10 (ii) For individual health insurance coverage, on the first day of the first policy year
66-11 beginning on or after September 23, 2010.
66-12 (2) For individual health insurance coverage, an individual is not entitled to reinstatement
66-13 under the health benefit plan under this subsection if the individual reached his or her lifetime
66-14 limit and the contract is not renewed or is otherwise no longer in effect. However, this subsection
66-15 applies to a family member who reached his or her lifetime limit in a family plan and other family
66-16 members remain covered under the plan.
66-17 (3)(A) If an individual described in subdivision (1) is eligible for benefits or is required
66-18 to become eligible for benefits under the health benefit plan, the health maintenance organization
66-19 shall provide the individual written notice that:
66-20 (i) The lifetime limit on the dollar value of all benefits no longer applies; and
66-21 (ii) The individual, if still covered under the plan, is again eligible to receive benefits
66-22 under the plan.
66-23 (B) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for,
66-24 but not enrolled in any benefit package under the plan, the health maintenance organization shall
66-25 provide an opportunity for the individual to enroll in the plan for a period of at least thirty (30)
66-26 days.
66-27 (C) The notices and enrollment opportunity under this subdivision shall be provided
66-28 beginning not later than:
66-29 (i) For group health insurance coverage, the first day of the first plan year beginning on
66-30 or after September 23, 2010; or
66-31 (ii) For individual health insurance coverage, the first day of the first policy year
66-32 beginning on or after September 23, 2010.
66-33 (iii) The notices required under this subsection shall be provided:
67-34 (I) For group health insurance coverage, to an employee on behalf of the employee's
67-35 dependent; or

67-36 (II) For individual health insurance coverage, to the primary subscriber on behalf of the
67-37 primary subscriber's dependent.

67-38 (D) For group health insurance coverage, the notices may be included with other
67-39 enrollment materials that a health maintenance organization distributes to subscribers, provided
67-40 the statement is prominent. For group health insurance coverage, if a notice satisfying the
67-41 requirements of this subsection is provided to an individual, a health maintenance organization's
67-42 requirement to provide the notice with respect to that individual is satisfied.

67-43 (E) For any individual who enrolls in a health maintenance organization in accordance
67-44 with subdivision (2) of this subsection, coverage under the plan shall take effect not later than:

67-45 (i) For group health insurance coverage, the first day of the first plan year beginning on
67-46 or after September 23, 2010; or

67-47 (ii) For individual health insurance coverage, the first day of the first policy year
67-48 beginning on or after September 23, 2010.

67-49 (d)(1) An individual enrolling in a health maintenance organization for group health
67-50 insurance coverage in accordance with subsection (c) above shall be treated as if the individual
67-51 were a special enrollee in the plan, as provided under regulations interpreting the HIPAA
67-52 portability provisions issued pursuant to Section 2714 of the Affordable Care Act.

67-53 (2) An individual enrolling in accordance with subsection (c) of this subsection:

67-54 (A) shall be offered all of the benefit packages available to similarly situated individuals
67-55 who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value
67-56 of all benefits; and

67-57 (B) shall not be required to pay more for coverage than similarly situated individuals who
67-58 did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

67-59 (3) For purposes of subsection B(1), any difference in benefits or cost-sharing constitutes
67-60 a different benefit package.

67-61 (e)(1) The provisions of this section relating to lifetime limits apply to any health
67-62 maintenance organization or health insurance carrier providing coverage under an individual or
67-63 group health plan, including grandfathered health plans.

67-64 (2) The provisions of this section relating to annual limits apply to any health
67-65 maintenance organization or health insurance carrier providing coverage under a group health
67-66 plan, including grandfathered health plans, but the prohibition and limits on annual limits do not
67-67 apply to grandfathered health plans providing individual health insurance coverage.

68-68 **27-41-77. Coverage for Preventive Items and Services. --** (a) Every health maintenance
68-69 organization providing coverage under an individual or group health plan shall provide coverage
68-70 for all of the following items and services, and shall not impose any cost-sharing requirements,
68-71 such as a copayment, coinsurance or deductible, with respect to the following items and services:

68-72 (1) Except as otherwise provided in subsection (b) of this section, and except as may
68-73 otherwise be provided in federal regulations implementing the Affordable Care Act, evidence-
68-74 based items or services that have in effect a rating of A or B in the recommendations of the
68-75 United States Preventive Services Task Force as of September 23, 2010 and as may subsequently
68-76 be amended.

68-77 (2) Immunizations for routine use in children, adolescents and adults that have in effect a
68-78 recommendation from the Advisory Committee on Immunization Practices of the Centers for
68-79 Disease Control and Prevention with respect to the individual involved. For purposes of this
68-80 subdivision, a recommendation from the Advisory Committee on Immunization Practices of the
68-81 Centers for Disease Control and Prevention is considered in effect after it has been adopted by the
68-82 Director of the Centers for Disease Control and Prevention, and a recommendation is considered
68-83 to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease
68-84 Control and Prevention.

68-85 (3) With respect to infants, children and adolescents, evidence-informed preventive care,
68-86 and screenings provided for in comprehensive guidelines supported by the Health Resources and
68-87 Services Administration.

68-88 (4) With respect to women, to the extent not described in subdivision (1) of this
68-89 subsection, evidence-informed preventive care and screenings provided for in comprehensive
68-90 coverage guidelines supported by the Health Resources and Services Administration.

68-91 (b)(1) A health maintenance organization is not required to provide coverage for any
68-92 items or services specified in any recommendation or guideline described in subsection (a) of this
68-93 section after the recommendation or guideline is no longer described in subsection (a) of this
68-94 section. The provisions of this subdivision shall not affect the obligation of the health
68-95 maintenance organization to provide notice to a covered person before any material modification
68-96 of coverage becomes effective, in accordance with including section 2715(d)(4) of the Public
68-97 Health Services Act.

68-98 (2) A health maintenance organization shall at least annually at the beginning of each
68-99 new plan year or policy year, whichever is applicable, revise the preventive services covered
68-100 under its health benefit plans pursuant to this section consistent with the recommendations of the
68-101 United States Preventive Services Task Force, the Advisory Committee on Immunization
68-102 Practices of the Centers for Disease Control and Prevention and the guidelines with respect to
69-1 infants, children, adolescents and women evidence-based preventive care and screenings by the
69-2 Health Resources and Services Administration in effect at the time.

69-3 (c)(1) A health maintenance organization insurance carrier may impose cost-sharing
69-4 requirements with respect to an office visit if an item or service described in subsection (a) of this
69-5 section is billed separately or is tracked as individual encounter data separately from the office
69-6 visit.

69-7 (2) A health maintenance organization shall not impose cost-sharing requirements with
69-8 respect to an office visit if an item or service described in subsection (a) of this section is not
69-9 billed separately or is not tracked as individual encounter data separately from the office visit and
69-10 the primary purpose of the office visit is the delivery of the item or service described in
69-11 subsection (a) of this section.

69-12 (3) A health maintenance organization may impose cost-sharing requirements with
69-13 respect to an office visit if an item or service described in subsection (a) of this section is not
69-14 billed separately or is not tracked as individual encounter data separately from the office visit and
69-15 the primary purpose of the office visit is not the delivery of the item or service.

69-16 (d)(1) Nothing in this section requires a health maintenance organization that has a
69-17 network of providers to providing coverage for items and services described in subsection (a) of
69-18 this section that are delivered by an out-of-network provider.

69-19 (2) Nothing in subsection (a) of this section precludes a health maintenance organization
69-20 insurance carrier that has a network of providers from imposing cost-sharing requirements for
69-21 items or services described in subsection (a) of this section that are delivered by an out-of-
69-22 network provider.

69-23 (e) Nothing prevents a health maintenance organization from using reasonable medical
69-24 management techniques to determine the frequency, method, treatment or setting for an item or
69-25 service described in subsection (a) of this section to the extent not specified in the
69-26 recommendation or guideline.

69-27 (f) Nothing in this section prohibits a health maintenance organization from providing
69-28 coverage for items and services in addition to those recommended by the United States
69-29 Preventive Services Task Force or the Advisory Committee on Immunization Practices of the
69-30 Centers for Disease Control and Prevention, or provided by guidelines supported by the Health
69-31 Resources and Services Administration, or from denying coverage for items and services that are
69-32 not recommended by that task force or that advisory committee, or under those guidelines. A
69-33 health maintenance organization may impose cost-sharing requirements for a treatment not
69-34 described in subsection (a) of this section even if the treatment results from an item or service
70-1 described in subsection (a) of this section.

70-2 (g) This section shall not apply to grandfathered health plans.

70-3 **27-41-78. Coverage for individual participating in approved clinical trials. -- (a) As**
70-4 used in this section.

70-5 (1) "Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial
70-6 that is conducted in relation to the prevention, detection or treatment of cancer or a life-
70-7 threatening disease or condition and is described in any of the following:

70-8 (A) The study or investigation is approved or funded, which may include funding through
70-9 in-kind contributions, by one or more of the following:

70-10 (i) The National Institutes of Health;
70-11 (ii) The Centers for Disease Control and Prevention;
70-12 (iii) The Agency for Health Care Research and Quality;
70-13 (iv) The Centers for Medicare & Medicaid Services;
70-14 (v) A cooperative group or center of any of the entities described in items (i) through (iv)
70-15 or the Department of Defense or the Department of Veteran Affairs;
70-16 (vi) A qualified non-governmental research entity identified in the guidelines issued by
70-17 the National Institutes of Health for center support grants; or
70-18 (vii) A study or investigation conducted by the Department of Veteran Affairs, the
70-19 Department of Defense, or the Department of Energy, if the study or investigation has been
70-20 reviewed and approved through a system of peer review that the Secretary of U.S. Department of
70-21 Health and Human Services determines:
70-22 (I) Is comparable to the system of peer review of studies and investigations used by the
70-23 National Institutes of Health; and
70-24 (II) Assures unbiased review of the highest scientific standards by qualified individuals
70-25 who have no interest in the outcome of the review.
70-26 (B) The study or investigation is conducted under an investigational new drug application
70-27 reviewed by the Food and Drug Administration; or
70-28 (C) The study or investigation is a drug trial that is exempt from having such an
70-29 investigational new drug application.
70-30 (2) "Participant" has the meaning stated in section 3(7) of ERISA.
70-31 (3) "Participating provider" means a health care provider that, under a contract with the
70-32 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
70-33 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
70-34 deductibles, directly or indirectly from the health carrier.
71-1 (4) "Qualified individual" means a participant or beneficiary who meets the following
71-2 conditions:
71-3 (A) The individual is eligible to participate in an approved clinical trial according to the
71-4 trial protocol with respect to the treatment of cancer or other life-threatening disease or condition;
71-5 and
71-6 (B)(i) The referring health care professional is a participating provider and has concluded
71-7 that the individual's participation in such trial would be appropriate based on the individual
71-8 meeting the conditions described in subdivision (A) of this subdivision (3); or
71-9 (ii) The participant or beneficiary provides medical and scientific information
71-10 establishing the individual's participation in such trial would be appropriate based on the
71-11 individual meeting the conditions described in subdivision (A) of this subdivision (3).
71-12 (5) "Life-threatening condition" means any disease or condition from which the
71-13 likelihood of death is probable unless the course of the disease or condition is interrupted.
71-14 (b)(1) If a health maintenance organization offering group or individual health insurance
71-15 coverage provides coverage to a qualified individual, it:
71-16 (A) Shall not deny the individual participation in an approved clinical trial.
71-17 (B) Subject to subdivision (3) of this subsection, shall not deny or limit or impose
71-18 additional conditions on the coverage of routine patient costs for items and services furnished in
71-19 connection with participation in the approved clinical trial; and
71-20 (C) Shall not discriminate against the individual on the basis of the individual's
71-21 participation in the approved clinical trial.
71-22 (2)(A) Subject to subdivision (B) of this subdivision (2), routine patient costs include all
71-23 items and services consistent with the coverage typically covered for a qualified individual who is
71-24 not enrolled in an approved clinical trial.
71-25 (B) For purposes of subdivision (B) of this subdivision (2), routine patient costs do not
71-26 include:
71-27 (i) The investigational item, device or service itself;
71-28 (ii) Items and services that are provided solely to satisfy data collection and analysis
71-29 needs and that are not used in the direct clinical management of the patient; or
71-30 (iii) A service that is clearly inconsistent with widely accepted and established standards

71-31 of care for a particular diagnosis.

71-32 (3) If one or more participating providers is participating in a clinical trial, nothing in
71-33 subdivision (1) of this subsection shall be construed as preventing a health maintenance
71-34 organization from requiring that a qualified individual participate in the trial through such a
72-1 participating provider if the provider will accept the individual as a participant in the trial.

72-2 (4) Notwithstanding subdivision (3) of this subsection, subdivision (1) of this subsection
72-3 shall apply to a qualified individual participating in an approved clinical trial that is conducted
72-4 outside this state.

72-5 (5) This section shall not be construed to require a health maintenance organization
72-6 offering group or individual health insurance coverage to provide benefits for routine patient care
72-7 services provided outside of the coverage's health care provider network unless out-of-network
72-8 benefits are other provided under the coverage.

72-9 (6) Nothing in this section shall be construed to limit a health maintenance organization's
72-10 coverage with respect to clinical trials.

72-11 (c) The requirements of this section shall be in addition to the requirements of Rhode
72-12 Island general laws sections 27-41-41 through 27-41-41.3.

72-13 **27-41-79. Medical loss ratio rebates. --** (a) A health maintenance organization offering
72-14 group or individual health insurance coverage, including a grandfathered health plan, shall pay
72-15 medical loss ratio rebates as provided for in section 2718(b)(1)(A) of the Affordable Care Act, in
72-16 the manner and as required by federal laws and regulations.

72-17 (b) Health maintenance organizations required to report medical loss ratio and rebate
72-18 calculations and any other medical loss ratio or rebate information to the U.S. Department of
72-19 Health and Human Services shall concurrently file such information with the commissioner.

72-20 **27-41-80. Emergency services. --** (a) As used in this section:

72-21 (1) "Emergency medical condition" means a medical condition manifesting itself by acute
72-22 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
72-23 possesses an average knowledge of health and medicine, could reasonably expect the absence of
72-24 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
72-25 with respect to a pregnant woman her unborn child in serious jeopardy; (ii) Constituting a serious
72-26 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
72-27 part.

72-28 (2) "Emergency services" means, with respect to an emergency medical condition:

72-29 (A) A medical screening examination (as required under section 1867 of the Social
72-30 Security Act, 42 U.S.C. 1395 dd) that is within the capability of the emergency department of a
72-31 hospital, including ancillary services routinely available to the emergency department to evaluate
72-32 such emergency medical condition, and

72-33 (B) Such further medical examination and treatment, to the extent they are within the
72-34 capabilities of the staff and facilities available at the hospital, as are required under section 1867
73-1 of the Social Security Act (42 U.S.C. 1395 dd) to stabilize the patient.

73-2 (3) "Stabilize", with respect to an emergency medical condition has the meaning given in
73-3 section 1867(e)(3) of the Social Security Act (42 U.S.C.1395 dd(e)(3)).

73-4 (b) If a health maintenance organization offering group health insurance coverage
73-5 provides any benefits with respect to services in an emergency department of a hospital, it must
73-6 cover emergency services consistent with the rules of this section.

73-7 (c) A health maintenance organization shall provide coverage for emergency services in
73-8 the following manner:

73-9 (1) Without the need for any prior authorization determination, even if the emergency
73-10 services are provided on an out-of-network basis;

73-11 (2) Without regard to whether the health care provider furnishing the emergency services
73-12 is a participating network provider with respect to the services;

73-13 (3) If the emergency services are provided out of network, without imposing any
73-14 administrative requirement or limitation on coverage that is more restrictive than the requirements
73-15 or limitations that apply to emergency services received from in-network providers;

73-16 (4) If the emergency services are provided out of network, by complying with the cost-
73-17 sharing requirements of subsection (d) of this section; and

73-18 (5) Without regard to any other term or condition of the coverage, other than:
73-19 (A) The exclusion of or coordination of benefits;
73-20 (B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title
73-21 XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or
73-22 (C) Applicable cost sharing.
73-23 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
73-24 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
73-25 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
73-26 the services were provided in-network; provided, however, that a participant or beneficiary may
73-27 be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-
73-28 network provider charges over the amount the plan or health maintenance organization is required
73-29 to pay under subdivision (1) of this subsection. A health maintenance organization complies with
73-30 the requirements of this subsection if it provides benefits with respect to an emergency service in
73-31 an amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
73-32 this subdivision (1)(which are adjusted for in-network cost-sharing requirements).
73-33 (A) The amount negotiated with in-network providers for the emergency service
73-34 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
74-1 participant or beneficiary. If there is more than one amount negotiated with in-network providers
74-2 for the emergency service, the amount described under this subdivision (A) is the median of these
74-3 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
74-4 participant or beneficiary. In determining the median described in the preceding sentence, the
74-5 amount negotiated with each in-network provider is treated as a separate amount (even if the
74-6 same amount is paid to more than one provider). If there is no per-service amount negotiated with
74-7 in-network providers (such as under a capitation or other similar payment arrangement), the
74-8 amount under this subdivision (A) is disregarded.
74-9 (B) The amount for the emergency service calculated using the same method the plan
74-10 generally uses to determine payments for out-of-network services (such as the usual, customary,
74-11 and reasonable amount), excluding any in-network copayment or coinsurance imposed with
74-12 respect to the participant or beneficiary. The amount in this subdivision (B) is determined without
74-13 reduction for out-of-network cost sharing that generally applies under the plan or health insurance
74-14 coverage with respect to out-of-network services.
74-15 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
74-16 Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network
74-17 copayment or coinsurance imposed with respect to the participant or beneficiary.
74-18 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
74-19 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
74-20 services provided out of network if the cost-sharing requirement generally applies to out-of-
74-21 network benefits. A deductible may be imposed with respect to out-of-network emergency
74-22 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
74-23 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
74-24 apply to out-of-network emergency services.
74-25 (e) The provisions of this section apply for plan years beginning on or after September
74-26 23, 2010.
74-27 (f) This section shall not apply to grandfathered health plans.
74-28 **27-41-81. Internal and external appeal of adverse benefit determinations. --** (a) The
74-29 commissioner shall adopt regulations to implement standards and procedures with respect to
74-30 internal claims and appeals of adverse benefit determinations, and with respect to external appeals
74-31 of adverse benefit determinations.
74-32 (b) The regulations adopted by the commissioner shall apply to those adverse benefit
74-33 determinations within the jurisdiction of the commissioner.^(add)

75-34 SECTION 10. Section 42-14-5 of the General laws in Chapter 42-14 entitled
75-35 "Department of Business Regulation" is hereby amended to read as follows:
75-36 **42-14-5. Administrator of banking and insurance. --** (a) The director of business
75-37 regulation shall, in addition to his or her regular duties, act as administrator of banking and
75-38 insurance and shall administer the functions of the department relating to the regulation and

75-39 control of banking and insurance, foreign surety companies, sale of securities, building and loan
 75-40 associations, and fraternal benefit and beneficiary societies.
 75-41 (b) Wherever the words "banking administrator" or "insurance administrator" occur in
 75-42 this chapter or any general law, public law, act, or resolution of the general assembly or
 75-43 department regulation, they shall be construed to mean banking commissioner and insurance
 75-44 commissioner except as delineated in subsection (d) below.
 75-45 (c) "Health insurance" shall mean "health insurance coverage," as defined in 27-18.5-2
 75-46 and 27-18.6-2, "health benefit plan," as defined in 27-50-3 and a "medical supplement policy," as
 75-47 defined in 27-18.2-1 or coverage similar to a Medicare supplement policy that is issued to an
 75-48 employer to cover retirees, and dental coverage, including, but not limited to, coverage provided
 75-49 by a nonprofit dental service plan as defined in subsection 27-20.1-1(3).
 75-50 (d) Whenever the words "commissioner," "insurance commissioner", "Health insurance
 75-51 commissioner" or "director" appear in Title 27 or Title 42, those words shall be construed to mean
 75-52 the health insurance commissioner established pursuant to 42-14.5-1 with respect to all matters
 75-53 relating to health insurance. The health insurance commissioner shall have sole and exclusive
 75-54 jurisdiction over enforcement of those statutes with respect to all matters relating to health
 75-55 insurance.
 75-56 ^{add}(e) In consultation with the commissioner of health, the health insurance commissioner
 75-57 shall have concurrent jurisdiction to monitor, examine, and enforce the requirements of title 23
 75-58 and regulations adopted thereunder relating to health insurance. ^{add}
 75-59 SECTION 11. ^{add}Applicability. This act shall apply to health insurance policies, subscriber
 75-60 contracts, and any other health benefit contract on and after July 1, 2012, except as otherwise
 75-61 provided by the provisions of this act. ^{add}
 75-62 SECTION 12. This act shall take effect on passage.

 <small>voting check off graphic</small>	To take no position on 12 H 7909 AN ACT RELATING TO INSURANCE -- HEALTH INSURANCE - CONSUMER PROTECTION		
 <small>Announcer graphic</small>	Announcements	Linda Ward	4:20
 <small>calendar graphic</small>	Agenda and Scheduling the Next Meeting Items to be placed on the next meeting's agenda: Next meeting will be on: Monday May 14 th , 3 - 4:30 PM	Linda Ward	4:25
 <small>alarm clock graphic</small>	Adjournment TSA Cares presentation on the new hotline for travelers with disabilities, Tuesday 4/10 @ 11 AM, GCD Conference Room. Wheelchair Accessible Taxi distribution Friday 4/13 @ 1 PM, Dunkin Donuts Center.	Linda Ward	4:30
 <small>voting check off graphic</small>	MOTION: To adjourn at 4:19 PM AS/JD passed unanimously		