State of Rhode Island and Providence Plantations

JOURNAL

-OF THE-

HOUSE OF REPRESENTATIVES

JANUARY SESSION of the General Assembly begun and held at the State House in the City of Providence on Tuesday, the fourth day of January in the year of Our Lord two thousand.

Volume 127, No. 64 Tuesday, June 27, 2000 Sixty-fourth Day

The House of Representatives meets at the State House in Providence, Tuesday, June 27, 2000, and is called to order at 4:27 o'clock P.M., by the Honorable John B. Harwood, Speaker.

The roll is called and a quorum is declared present with 96 members present and 4 members absent as follows:

PRESENT - 96: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit. Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carroll, Carter, Cicilline, Coderre, Coelho, Corvese Costantino, Dennigan, DeSimone, Faria, Flaherty. Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C. Levesque, G., Lewiss, Lima, Long, Lopes, Lowe, Maher, Malik, Martineau, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Quick, Rabideau, Reilly, Rose, Russo, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith. Sullivan, Thompson, Vieira, Voccola, Watson, Williams, Williamson. Winfield.

ABSENT - 4: Representatives Crowley, Ferguson, Hetherington, Wasylyk.

INVOCATION

The Honorable Speaker presents Representative Lewiss, who delivers the Invocation and leads the membership in the Pledge of Allegiance to the Flag.

(For Invocation, see Appendix, this Journal.)

CORRECTION

By unanimous consent, the House Journal of Friday, June 23, 2000 is hereby corrected on page 3, column 2 after the vote for (2000-H 7318) by inserting the following:

Representative Naughton requests the Journal to reflect that her machine malfunctioned on

(2000-H 7318), it should have recorded a vote in the negative.

There is no objection.

APPROVAL OF RECORD

By unanimous consent, the House Journal of Friday, June 23, 2000, is approved as corrected.

APPROVED BY THE GOVERNOR

The Honorable Speaker announces receipt by the Secretary of State of the following measure, approved and signed by His Excellency, the Governor:

(2000-H 8041) An Act authorizing the town of Coventry to finance the acquisition and improvement of land for recreational purposes by the issuance of not more than, $2,000,000 bonds and/ or notes therefor, approved June 23, 2000.

Received and ordered to be placed on file.

GUESTS

Representative G. Levesque welcomes to the House chambers as guests his sister Mary and students from the Naval Justice School as follows: Honorable Napaporn Tawornsitli, Judge from Thailand; Hugo Causo, Attorney and Naval Officer from Italy; and Rupin Hunspaul from Canada.

Also:

The Honorable Speaker Harwood and Representative Amaral welcome to the House chambers as a guest High Sheriff Thomas Hodgeson.

Also:

The Honorable Speaker Harwood along with Representatives Vieira, San Bento, M. Anderson and Kilmartin, welcome to the House chambers as guests Tolman High School Lady Tigers Girls State Championship Softball Team as follows: Stephanie Malone, Nicole O'Laughlin, Christine McKenna, Meaghan Cullinan, Tina Jardine, Melissa Cooper, Amanda Mousseau, Kim Brunelle, Caitlin Carter, Noelle Fontaine, Kelli Fleury, Debra Vieira, Head Coach Tom Vecoli, and Assistant Coach Kevin Lipsett.

COMMUNICATION FROM THE SENATE

A message from the Honorable Senate transmits with announcement of passage of the following measures:

(00-S 2587 as amended) An Act relating to the retirement system - membership and service credits.

Read and ordered to be placed on the Calendar.

(00-S 3006) An Act making an appropriation to pay certain claims.

Read and ordered to be placed on the Calendar.

REPORTS OF COMMITTEES

COMMITTEE ON FINANCE

Representative Pires, for the Committee on Finance, reports back the following measure, with recommendation of passage:

(2000-H 7580) (Substitute "A") An Act relating to use of vehicles by law enforcement officers.

Received and ordered to be placed on the Calendar.

COMMITTEE ON CORPORATIONS

Representative Kennedy, for the Committee on Corporations, reports back the following measure, with recommendation of passage:

(2000-H 8294) An Act relating to property subject to taxation.

Received and ordered to be placed on the Consent Calendar.

TRANSFER OF BILL

Representative Flaherty, for the Committee on Judiciary, reports back the following measure, with recommendation of transfer to the Committee on Finance:

(00-S 2737) An Act relating to motor vehicles.

Received and referred to the Committee on Finance.

COMMITTEE ON JUDICIARY

Representative Flaherty, for the Committee on Judiciary, reports back the following measures, with recommendation of passage:

(00-S 2130) (Substitute "A") An Act relating to property- aircraft repair liens.

Received and ordered to be placed on the Calendar.

(00-S 2208) Joint Resolution creating a special legislative commission to study services to persons with mental illness in the criminal justice system.

Received and ordered to be placed on the Calendar.

(00-S 2241) (Substitute "A") An Act relating to mental health law.

Received and ordered to be placed on the Calendar.

(00-S 2327) An Act relating to exchange of information in support of child support collection.

Received and ordered to be placed on the Calendar.

(00-S 2338) An Act relating to highways -freeways.

Received and ordered to be placed on the Calendar.

(00-S 2431) (Substitute "A") An Act relating to animals - cruelty to animals.

Received and ordered to be placed on the Calendar.

(00-S 2470) (Substitute "B") An Act relating to motor vehicle offenses.

Received and ordered to be placed on the Calendar.

(00-S 2514) An Act relating to the Rhode Island Whistleblowers' Protective Act.

Received and ordered to be placed on the Calendar.

(00-S 2547) (Substitute "A") An Act relating to businesses and professions health care communications.

Received and ordered to be placed on the Calendar.

(00-S 2638) (Substitute "A") An Act relating to taxation cigarette tax.

Received and ordered to be placed on the Calendar.

(00-S 2645) An Act relating to public officers and employees.

Received and ordered to be placed on the Calendar.

(00-S 2704) (Substitute "A") An Act relating to criminal offenses - sex offender central registry.

Received and ordered to be placed on the Calendar.

(00-S 2770) (Substitute "A" as amended) An Act relating to indictments, informations and complaints.

Received and ordered to be placed on the Calendar.

(00-S 2966) (Substitute "B") An Act relating to motor and other vehicles.

Received and ordered to be placed on the Calendar.

(00-S 3044) An Act relating to solemnization of marriage.

Received and ordered to be placed on the Calendar.

(2000-H 6727 as amended) An Act relating to businesses and professions - telephone sales -- solicitation.

Received and ordered to be placed on the Calendar.

(2000-H 7692) An Act relating to exchange of information in support of child support collection.

Received and ordered to be placed on the Calendar.

(2000-H 8249) (Substitute "A") An Act relating to noise limits for motor vehicles.

Received and ordered to be placed on the Calendar.

(2000-H 8319) (Substitute "A") An Act relating to businesses and professions - immunity from civil liability to architects, engineers, land surveyors and landscape architects.

Received and ordered to be placed on the Calendar.

(2000-H 8373) An Act relating to criminal procedure mandatory protection and supervision of witnesses.

Received and ordered to be placed on the Calendar.

COMMITTEE ON CORPORATIONS

Representative Kennedy, for the Committee on Corporations, reports back the following measures, with recommendation of passage

(00-S 2114) (Substitute "A") An Act relating to highways- construction and maintenance.

Received and ordered to be placed on the Calendar.

(00-S 2344) An Act relating to businesses and professions psychologists.

Received and ordered to be placed on the Calendar.

(00-S 2434 as amended) An Act relating to tree wardens.

Received and ordered to be placed on the Calendar.

(00-S 2474) An Act relating to insurance -agents, brokers and solicitors.

Received and ordered to be placed on the Calendar.

(00-S 2483) (Substitute "A" as amended) An Act relating to the hospital conversions act.

Received and ordered to be placed on the Calendar.

(00-S 2486) (Substitute "A") An Act relating to professional service corporations.

Received and ordered to be placed on the Calendar.

(00-S 2569 as amended) An Act relating to state affairs and government - electronic signatures and records act.

Received and ordered to be placed on the Calendar.

(00-S 2631) An Act relating to insurance.

Received and ordered to be placed on the Calendar.

(00-S 2665) An Act relating to incorporation of United Electric Power Company.

Received and ordered to be placed on the Calendar.

(00-S 2677) (Substitute A as amended) An Act authorizing the city of Providence to issue bonds and notes in an amount not exceeding fifty million ($50,000,000) dollars for the purpose of redevelopment and/or capital improvements.

Received and ordered to be placed on the Calendar.

(00-S 2912) An Act relating to cities and towns.

Received and ordered to be placed on the Calendar.

(00-S 2987) An Act exempting from taxation the real, mixed and personal property of the Burrillville Glocester Youth Soccer Association. Inc.

Received and ordered to be placed on the Calendar.

(00-S 2991) An Act relating to property subject to taxation.

Received and ordered to be placed on the Calendar.

(00-S 2992) An Act relating to levy and assessment of local taxes.

Received and ordered to be placed on the Calendar.

(00-S 3007) An Act authorizing the town of Lincoln to issue general obligation bonds and notes in an amount not to exceed one million dollars for the purpose of acquiring and preserving open space and acquiring, preserving, constructing or improving recreational areas or facilities in the town.

Received and ordered to be placed on the Calendar.

(00-S 3008) An Act authorizing the city of Cranston to finance the acquisition, construction, improvement, renovation, alteration, repair and equipping of infrastructure including, but not limited to, protective improvements to the city's shoreline along Narragansett Bay, sidewalk, highway and traffic control improvements, landscaping and lighting by the issuance of not more than $4,000,000 bonds and notes therefor.

Received and ordered to be placed on the Calendar.

(00-S 3009) An Act authorizing the city of Cranston to finance the renovation, rehabilitation, repair, improvement, furnishing and equipping of schools and school facilities including, but not limited to, additions to Cranston High School East and the Western Hills Middle School and improvements to the Park View Middle School in the city by the issuance of not more than $13,865,000 bonds and notes therefor.

Received and ordered to be placed on the Calendar.

(00-S 3010) An Act authorizing the city of Cranston to finance the construction, reconstruction and installation of storm drains and the acquisition of public works equipment necessary for storm drain operation by the issuance of not more than $900,000 bonds and notes therefor.

Received and ordered to be placed on the Calendar.

(00-S 3012) An Act authorizing the city of Cranston to finance the construction, furnishing and equipping of a new police station in the city including land acquisition by the issuance of not more than $13,100,000 bonds and notes therefor.

Received and ordered to be placed on the Calendar.

(00-S 3013) An Act authorizing the city of Cranston to finance the acquisition and preservation of open space by the issuance of not more than $1,000,000 bonds and notes therefor.

Received and ordered to be placed on the Calendar.

(00-S 3040) An Act to vacate the forfeiture or revocation of the charter of One Stop Hardware of Providence, Inc.

Received and ordered to be placed on the Calendar.

(2000-H 7772) (Substitute "A") An Act relating to public buildings - public property and works.

Received and ordered to be placed on the Calendar.

(2000-H 8179) (Substitute "A") An Act relating to the state building and fire code.

Received and ordered to be placed on the Calendar.

(2000-H 8256) (Substitute "A") An Act relating to insurance.

Received and ordered to be placed on the Calendar.

(2000-H 8279) (Substitute "A") An Act relating to pharmacy.

Received and ordered to be placed on the Calendar.

(2000-H 8352) An Act to vacate the forfeiture or revocation of the charter of Hurdis Drilling Co., Inc.

Received and ordered to be placed on the Calendar.

COMMITTEE ON FINANCE

Representative Pires, for the Committee on Finance, reports back the following measures, with recommendation of passage:

(00-S 2329) An Act making an appropriation of $5,000 to Laura A. Hoxsie.

Received and ordered to be placed on the Calendar.

(00-S 2643) (Substitute "B") An Act relating to criminal offenses sexual offender registration and community notification.

Received and ordered to be placed on the Calendar.

(2000-H 7018) (Substitute "A") An Act relating to children.

Received and ordered to be placed on the Calendar.

(2000-H 7136) An Act relating to public assistance.

Received and ordered to be placed on the Calendar.

(2000-H 7159) (Substitute "A") An Act relating to human services- health care for elderly and disabled residents.

Received and ordered to be placed on the Calendar.

(2000-H 7199) An Act relating to the Pharmaceutical Assistance to the Elderly Act.

Received and ordered to be placed on the Calendar.

(2000-H 7342) (Substitute "A") An Act relating to sexual offender registration.

Received and ordered to be placed on the Calendar.

(2000-H 7350) (Substitute "A") An Act relating to courts and civil procedure - Family Court.

Received and ordered to be placed on the Calendar.

(2000-H 7425) An Act relating to labor and labor relations.

Received and ordered to be placed on the Calendar.

(2000-H 7501) (Substitute "A") An Act relating to state affairs and government - state lottery.

Received and ordered to be placed on the Calendar.

(2000-H 7925) (Substitute "A") An Act relating to taxation - declaration of estimated tax by corporation.

Received and ordered to be placed on the Calendar.

(2000-H 7954) (Substitute "A") An Act relating to public utilities cable access.

Received and ordered to be placed on the Calendar.

(2000-H 8222) (Substitute "A") An Act relating to the Board of Governors for Higher Education - research positions.

Received and ordered to be placed on the Calendar.

(2000-H 8331) An Act relating to health insurance - premium assessments.

Received and ordered to be placed on the Calendar.

COMMITTEE ON LABOR

Representative Faria, for the Committee on Labor, reports back the following measures, with recommendation of passage:

(00-S 2580) An Act relating to businesses and professions- plumbers.

Received and ordered to be placed on the Calendar.

(00-S 2593) An Act relating to labor and labor relations- Division of Professional Regulation.

Received and ordered to be placed on the Calendar.

COMMUNICATION FROM THE SENATE

A message from the Honorable Senate transmits with announcement of passage, of the following measures:

(00-S 2954) An Act relating to the Bonnet Shores Fire District.

Read and referred to the Committee on Corporations.

(00-S 3036) An Act authorizing the town of Portsmouth to finance the construction of an athletic facility at Portsmouth High School by the issuance of not more than $3,500,000 bonds and/ or notes therefor.

Read and referred to the Committee on Corporations.

(00-S 3037) An Act authorizing the town of Cumberland to issue general obligation bonds and notes for the purpose of acquiring and preserving open space and acquiring, preserving, restoring or improving recreational areas, and to issue not more than $1,500,000 bonds and notes therefor.

Read and referred to the Committee on Corporations.

(00-S 3039) An Act authorizing the town of Cumberland to finance construction of additions, renovations and repairs to the public schools and public buildings in the town, including the furnishing of equipment and furniture in connection therewith and the provision of architectural, engineering, surveying and other services necessary or appropriate therefor, and to issue not more than $3,000,000 bonds and notes therefor.

Read and referred to the Committee on Corporations.

(00-S 3042) An Act authorizing the town of New Shoreham to finance the acquisition of open space for preservation and groundwater protection and the development of public recreational facilities in the town by the issuance of not more than $1,000,000 bonds and/or notes therefor.

Read and referred to the Committee on Corporations.

(00-S 3043) An Act authorizing the town of North Kingstown to finance the acquisition of development rights to farmland and other real estate and to issue not more than $4,000,000 bonds and notes therefor.

Read and referred to the Committee on Corporations.

(00-S 2089) (Substitute "A") An Act relating to the Department of Children, Youth and Families.

Read and referred to the Committee on Finance.

(00-S 2098) (Substitute "A") An Act relating to state agencies and public corporation financial integrity and accountability.

Read and referred to the Committee on Finance.

(00-S 2122) (Substitute "A") An Act relating to commercial fisheries.

Read and referred to the Committee on Finance.

(00-S 2159) An Act relating to state affairs and government mounted video/audio surveillance cameras - State Police.

Read and referred to the Committee on Finance.

(00-S 2176) An Act relating to taxation.

Read and referred to the Committee on Finance.

(00-S 2240) (Substitute "A") An Act relating to the pharmaceutical assistance to the elderly act eligible drugs.

Read and referred to the Committee on Finance.

(00-S 2280) (Substitute "A") An Act relating to taxation.

Read and referred to the Committee on Finance.

(00-S 2290 as amended) An Act relating to human services- medical assistance.

Read and referred to the Committee on Finance.

(00-S 2387) (Substitute "A") An Act relating to education- requiring certain schools to institute a breakfast program.

Read and referred to the Committee on Finance.

(00-S 2501 as amended) An Act relating to the Corrections Department.

Read and referred to the Committee on Finance.

(00-S 2528) (Substitute "A") An Act relating to human services.

Read and referred to the Committee on Finance.

(00-S 2529) (Substitute "A") An Act relating to human services- health care for the elderly and disabled residents.

Read and referred to the Committee on Finance.

(00-S 2574) (Substitute "A") An Act relating to health and safety - public access defibrillation.

Read and referred to the Committee on Finance.

(00-S 2675) (Substitute "A" as amended) An Act relating to taxation - investment tax credit.

Read and referred to the Committee on Finance.

(00-S 2688) An Act relating to the Downcity section of Providence.

Read and referred to the Committee on Finance.

(00-S 2760) (Substitute "A") An Act relating to Board of Governors for Higher Education.

Read and referred to the Committee on Finance.

(00-S 2840) (Substitute "A") An Act relating to public assistance.

Read and referred to the Committee on Finance.

(00-S 2863) (Substitute "A") An Act relating to pharmaceutical assistance to the elderly.

Read and referred to the Committee on Finance.

(00-S 2898) (Substitute "A" as amended) An Act making an appropriation of $96,000 for the National World War II Memorial in Washington, DC.

Read and referred to the Committee on Finance.

(00-S 3019) An Act authorizing the town of Middletown, with the approval of the qualified electors, to issue bonds and notes for the construction, improvement, renovation, furnishing and equipping of library facilities.

Read and referred to the Committee on Corporations.

(00-S 3020) An Act authorizing the city of Warwick to issue bonds and notes in an amount not to exceed $2,000,000 for renovation and repair of municipal buildings and neighborhood preservation.

Read and referred to the Committee on Corporations.

(00-S 3021) An Act authorizing the city of Warwick to issue bonds and notes in an amount not to exceed $7,000,000 for improvements and expansion of the ice arenas of the city of Warwick.

Read and referred to the Committee on Corporations.

(00-S 3022) An Act authorizing the city of Warwick to issue bonds and notes in an amount not to exceed $3,000,000 for renovation and improvement of the water system infrastructure of the city of Warwick.

Read and referred to the Committee on Corporations.

(00-S 3023) An Act authorizing the town of Bristol to issue general obligation bonds and notes in anticipation thereof in an amount not to exceed $2,000,000 for the purpose of financing the construction of additions, renovations and repairs to certain improved property in Bristol, Rhode Island known as Rogers Free Library, including the furnishing and equipping thereof, and the provision of architectural, engineering, surveying and other services necessary or appropriate therefor.

Read and referred to the Committee on Corporations.

(00-S 3032) An Act relating to city housing authorities.

Read and referred to the Committee on Corporations.

(00-S 3035) An Act authorizing the town of Charlestown to finance the acquisition, preservation or protection of open space or any interest therein alone or in conjunction with federal agencies, state agencies, land conservancies, land trusts or preservation organizations for preservation, groundwater protection or the development of public recreational facilities in the town by the issuance of not more than $2,000,000 bonds and/ or notes therefor.

Read and referred to the Committee on Corporations.

(00-S 2989) (Substitute "A") An Act relating to criminal procedure - public defender.

Read and referred to the Committee on Judiciary.

(00-S 3031) An Act relating to elections.

Read and referred to the Committee on Judiciary.

NEW BUSINESS

Representative M. Anderson introduces (2000-H 8397) Joint Resolution to approve and publish and submit to the electors a proposition of amendment to the Constitution of the State (General Assembly).

Read and referred to the Committee on Finance.

Representative Heffner introduces (2000-H 8398) House Resolution creating a special House commission to study the increased use of the internet and information technologies to improve efficiencies in state government.

Read and referred to the Committee on Corporations.

Representatives Inman, Sherlock, Simonian, Watson, Malik and several other members of the House introduce (2000-H 8399) House Resolution commemorating the 50th Anniversary of the Korean War and thanking the American soldiers for saving freedom on the Korean Peninsula.

Representative Inman requests unanimous consent for immediate consideration.

There is no objection.

Read and passed, on motion of Representative Inman, seconded by the entire House of Representatives, and by unanimous consent, on a voice vote.

Representatives Caprio, Garvey, Kelley and Kennedy introduce (2000-H 8400) House Resolution congratulating Will Thomas on winning the Pentathlon at the National Scholastic Track and Field Championships.

Representative Caprio requests unanimous consent for immediate consideration.

There is no objection.

Read and passed, on motion of Representative Caprio, seconded by the entire House of Representatives, and by unanimous consent, on a voice vote.

Representatives Garvey and Kennedy introduce (2000-H 8401) An Act relating to the town of Charlestown.

Representative Garvey requests unanimous consent for immediate consideration.

There is no objection.

Read and passed, on motion of Representative Garvey, seconded by Representative Kennedy, and by unanimous consent, on a roll call vote, 82 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 82: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Ail:en, Ajello, Almeida, Amaral, Anderson, M., Anderson, 5., Barr, Benoit, Benson, Bramley, Callahan, Cambio, Caprio, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone. Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George,

Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Lopes, Maher, Martineau, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater(Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -O.

Representative Lally introduces (2000-H 8402) An Act relating to the Bonnet Shores Fire District.

Representative Lally requests unanimous consent for immediate consideration.

There is no objection.

Read and passed, on motion of Representative Lally, seconded by Representatives Caprio, Benson and Montanaro, and by unanimous consent, on a roll call vote, 83 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS 83: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, 5., Barr, Benoit, Benson, Bramley, Callahan, Cambio, Caprio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, 6., Lewiss, Lima, Lopes, Maher, Martineau, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield

NAYS -fl.

Representatives Naughton, Henseler, Crowley, Rabideau and Ginaitt introduce (2000-H 8403) House Resolution reinstating the life of and extending the reporting and expiration dates of the special House commission to develop and plan to promote, protect and stimulate aquaculture commerce in Rhode Island.

Representative Naughton requests unanimous consent for immediate consideration.

There is no objection.

Read and passed, on motion of Representative Naughton, seconded by Representatives Henseler, Carter and Kelley, and by unanimous consent, on a voice vote.

NOTICES OF BILL/RESOLUTION

INTRODUCTION

Representative Carter gives notice that on the next legislative day he will introduce a measure concerning commission to study veterans benefits.

This notice is given in compliance with House Rule 42.

KENNETH CARTER
Representative, District 46

Received and ordered to be placed on file.

Representative M. Anderson gives notice that on the next legislative day she will introduce a measure concerning referenda.

This notice is given in compliance with House Rule 42.

MABEL M. ANDERSON
Representative, District 77

Received and ordered to be placed on file.

Representative Inman gives notice that on the next legislative day he will introduce a measure relating to health and safety.

This notice is given in compliance with House Rule 42.

EDWARD S. INMAN, III
Representative, District 41

Received and ordered to be placed on file.

RECONSIDER

Representative Slater moves to reconsider (00-S 2677) (Substitute "A"), seconded by Representatives Costantino, Palangio and Kennedy.

There is no objection.

The act is reconsidered, by unanimous consent, on a voice vote.

(00-S 2677) (Substitute "A") An Act authorizing the city of Providence to issue bonds and notes in an amount not exceeding fifty million ($50,000,000) dollars for the purpose of redevelopment and/or capital improvements.

Representative Slater moves to recommit the act, seconded by Representatives Costantino, Palangio and Kennedy.

Read and referred to the Committee on Corporations.

CALENDAR

Representative Martineau requests leave of the House with agreement of the Majority and the Minority to take up #1 on the Calendar for Thursday, June 29, 2000, first on today's Calendar.

There is no objection.

1.(2000-H 8075) (Substitute "A") An Act relating to retirement of municipal employees.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

The bill marked Substitute "A" is read and passed, and the original bill indefinitely postponed, on motion of Representative Jacquard, seconded by Representatives Montanaro, Lanzi and Palumbo, on a roll call vote, 78 members

voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 78: The Honorable Speaker Harwood and Representatives Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Bramley, Burlingame, Callahan, Cambio, Carpenter, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lanzi, Levesque, C., Lewiss, Lima. Lopes, Maher, Malik, Martineau, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Vieira. Voccola, Watson, Williams, Winfield.

NAYS -O.

Representative Abdullah-Odiase requests the journal to reflect that if she had voted on the act, she would have voted in the affirmative.

There is no objection.

TRANSMITTAL

By unanimous consent, (2000-H 8075) (Substitute "A") on the Clerk's desk is ordered to be transmitted to the Honorable Senate forthwith.

CALENDAR

From the Calendar for Tuesday, June 27, 2000 are taken:

1.(2000-H 7696) (Substitute "A" An Act relating to rates of payment to nursing facilities.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

Representative Sherlock moves passage of the act, seconded by Representative Inman.

By unanimous consent, Representative inman, seconded by Representatives Pires, 5. Anderson, Sherlock, George and Barr, offers the following written motion to amend:

FLOOR AMENDMENT

TO

(2000-H 7696) (Substitute "A")

Mr. Speaker:

I hereby move to amend (2000-H 7696) (Substitute "A") entitled "AN ACT RELATING TO RATES OF PAYMENT TO NURSING FACILITIES", as follows:

On page 4, line 15, by deleting the date "January 1, 2000" and inserting in place thereof the date "January 1, 2001."

Respectfully submitted,

EDWARD S. INMAN, III
Representative, District 41

The motion to amend is read and prevails on a roll call vote, 75 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 75: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carter, Coderre, Corvese, Costantino, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lanzi, Levesque, C., Lewiss, Lima, Lopes, Lowe, Maher, Malik, Martineau, McCauley, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -A

Representatives Abdullah-Odiase and Sherlock discuss the act as amended.

The bill marked Substitute "A" is read and passed, as amended, and the original bill indefinitely postponed, on a roll call vote, 81 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 81: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Ail:en, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carter, Coderre, Corvese, Costantino, Dennigan. Faria, Flaherty, Fleury, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lanzi, Levesque, C. Levesque, G., Lewiss, Lima, Lopes, Lowe, Maher, Malik, Martineau, McCauley, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Voccola, Watson. Williams, Winfield.

NAYS -O.

2.(2000-H 6871) (Substitute "A") Joint Resolution making an appropriation to pay certain claims.

Joint Committee on Accounts and Claims recommends indefinite postponement of the original bill and passage of Substitute "A"

The bill marked Substitute "A" is read and passed, and the original bill indefinitely postponed, on motion of Representative Carpenter, seconded by Representatives Slater, Moura, Simonian, Hogan and McNamara, on a roll call vote, 79 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 79: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello. Almeida, Amaral, Anderson, M., Anderson, S., Barr, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter Carter, Coderre, Corvese, Costantino, Dennigan, Faria, Flaherty, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lanzi, Levesque, C., Levesque, G.. Lewiss. Lima, Lopes, Lowe, Maher, Malik, Martineau, McCauley, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy. Murphy, Naughton, Palangio. Palumbo, Picard. Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento. Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -O.

3.(2000-H 8100 as amended) Joint Resolution making an appropriation of $8,052.75 to pay the claim of Georgiaville

Baptist Church, 100 Farnum Pike, P.O. Box 17474, Esmond, Rhode Island 02912-0705.

Joint Committee on Accounts and Claims recommends passage as amended.

Read and passed, as amended, on motion of Representative Carpenter, seconded by Representatives Ajello, Jacquard, Hogan and Winfield, on a roll call vote, 77 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS 77: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carter, Coderre, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Lopes, Lowe, Maher, Malik, Martineau, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Sullivan, Thompson, Vieira, Voccola, Williams, Winfield.

NAYS fl.

(2000-H 6899) (Substitute "A") An Act relating to Rhode Island Climate Change Initiative.

Joint Committee on Environment and Energy recommends indefinite postponement of the original bill and passage of Substitute "A".

Representative Ginaitt moves passage of the act, seconded by Representatives Rabideau and Reilly.

By unanimous consent, Representative Rabideau, seconded by Representative Ginaitt, offers the following written motion to amend:

FLOOR AMENDMENT

TO

(2000-H 6899) (Substitute "A")

Mr. Speaker:

I hereby move to amend (2000-H 6899) (Substitute "A") entitled "AN ACT RELATING TO RHODE ISLAND CLIMATE CHANGE INITIATIVE", as follows:

By deleting all of the language following the enactment clause and inserting in place thereof the following: "HOUSE RESOLUTION CREATING A SPECIAL COMMISSION TO STUDY THE DISCHARGE OF GASEOUS CARBONS INTO THE ATMOSPHERE:

RESOLVED, That a special legislative commission be and the same is hereby created of seven (7) members: four (4) of whom shall be from the house of representatives, not more than three (3) from the same political party, to be appointed by the speaker; three (3) of whom shall be from the senate, not more than two (2) from the same political party, to be appointed by the senate majority leader.

The purpose of said commission shall be to study the discharge of gaseous carbons into the atmosphere and the ability of trees to absorb the same and convert it into inert biomasses and to recommend steps to foster this process.

Forthwith upon the passage of this resolution the members of the commission shall meet at the call of the speaker of the house and organize and shall select from among the members a chairperson. Vacancies in said commission shall be filled in like manners as the original appointment.

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

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

RESOLVED, That the commission shall report its findings and recommendations to the general assembly on or before February 1, 2001 and said commission shall expire on April 1, 2001."

Respectfully submitted,

SCOTT P. RABIDEAU
Representative, District 60

The motion to amend is read and prevails on a roll call vote, 80 members voting in the affirmative and 1 member voting in the negative as follows:

YEAS - 80: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carter, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lanzi, Levesque, C., Lewiss, Lima, Lopes, Lowe, Maher, Malik, Martineau, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Voccola, Watson, Williams, Winfield.

NAYS - 1: Representative Levesque, G.

The bill marked Substitute "A" is read and passed, as amended, and the original bill indefinitely postponed, on a roll call vote, 80 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 80: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carter, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Lowe, Maher, Malik, Martineau, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Voccola, Watson, Williams, Winfield.

NAYS -OF

(2000-H 7109) House Resolution creating a special House commission to study alternate sites for a landfill.

Joint Committee on Environment and Energy recommends passage.

Read and passed, on motion of Representative Ginaitt, seconded by Representatives Cambio and Slater, on a roll call vote, 83 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 83: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Ail:en, Ajello, Almeida, Amaral,

Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carroll, Carter, Coderre, Corvese, Costantino, Dennigan, (DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lanzi, Levesque, C.. Levesque, G., Lewiss, Lima, Lopes, Lowe, Maher, Malik, Martineau, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, Russo, San Bento, Savage, Schadone, Shavers, Sherlock. Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson. Williams, Winfield.

NAYS -0.

6.(2000-H 7744) (Substitute "A") An Act relating to state affairs and government administrative adjudication for environmental matters.

Joint Committee on Environment and Energy recommends indefinite postponement of the original bill and passage of Substitute "A"

The bill marked Substitute "A" is read and passed, and the original bill indefinitely postponed, on motion of Representative Ginaitt, seconded by Representatives Henseler and Rabideau, on a roll call vote, 83 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 83: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello. Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carroll, Carter, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey(George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Lopes, Lowe, Maher. Malik, Martineau, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

7.(2000-H 8092) An Act relating to the Board of Dental Examiners.

Committee on Health, Education and Welfare recommends passage.

Read and passed, on motion of Representative Benoit, seconded by Representatives Simonian, Cambio, Benson, Ginaitt, Slater and Garabedian, on a roll call vote, 82 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 82: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carroll, Carter, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Lopes, Lowe, Maher, Malik, Martineau, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

8.(2000-H 8360) (Substitute "A") An Act relating to Health Reform, R.I. 2000 - RIte Care stabilization, small employer insurance reform, and health insurers' accountability.

Committee on Health, Education and Welfare recommends indefinite postponement of the original bill and passage of

Substitute "A".

Majority Leader Martineau extends thanks to all who had part in crafting this act and to Representative Benoit for the enormous amount of time she put into this act.

Representative Benoit moves passage of the act, seconded by Representatives Ginaitt, Reilly, Benson, Moura, Abdullah-Odiase, Shavers-, Cicilline, Hogan, Mumford, Kelley, Savage, Cambio, Thompson, Munschy, Slater, Fox, Carter and several other members of the House.

By unanimous consent, Representative Benoit, seconded by Representatives Ginaitt, Reilly, Benson, Moura, Abdullah-Odiase, Shavers, Cicilline, Hogan, Kelley, Mumford, Savage, Cambio, Thompson, Munschy, Slater, Fox, Carter and several other members of the House, offers a written motion to amend.

(For Floor Amendment LC3842, see Appendix, this Journal.)

The motion to amend is read and prevails on a roll call vote, 85 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 85: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Cambio, Caprio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Ferguson, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham. Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G.. Lima, Lowe, Maher, Malik, Martineau, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford. Munschy, Murphy, Naughton, Palangio, Picard. Pires. Pisaturo, Rabideau, Reilly, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Watson, Williams, Winfield.

NAYS -0.

By unanimous consent, Representative Benoit, seconded by Representative Ginaitt, Reilly, Benson, Moura, Abdullah-Odiase, Shavers, Cicilline, Hogan, Kelley, Mumford, Savage. Cambio, Thompson, Munschy, Slater, Fox, Carter and several other members of the House, offers the following written motion to amend:

FLOOR AMENDMENT

TO

(2000-H 8360) (Substitute "A")

Mr. Speaker:

I hereby move to amend (2000-H 8360) (Substitute "A") entitled "AN ACT RELATING TO HEALTH REFORM, R.I. 2000 - RITE CARE STABILIZATION, SMALL EMPLOYER INSURANCE REFORM, AND HEALTH INSURERS' ACCOUNTABILITY", as follows:

1. Page 6, line 17, deleting the language "from any health";

2. Page 6, line 17, by inserting the following language after the period and before the word "The": "The committee may request information from any health care provider, health care facility, insurer or

3. Page 6, line 18, by deleting the language "care facility and":

4. Page 9, line 1, by deleting the word "adjusted"'.

5. Page 13, line 24, by inserting the word "had" after the word "has":

6. Page 21, lines 25 and 26, by deleting the parentheses and the language "(Civilian Health and Medical Program of the Uniformed Services (CHAMPUS))";

7. Page 62, line 24, by deleting the language "to provide for establishment of a reinsurance program,"

8. Page 80, line 5, by inserting the following language after the word "exclusion"; "by the aggregate of the periods of creditable coverage".

Respectfully submitted

NANCY L. BENOIT
Representative, District 64

The motion to amend is read and prevails on a roll call vote, 86 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 86: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit. Benson, Bramley, Burlingame, Cambio, Caprio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Lowe, Maher, Malik, Martineau, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard. Pires, Pisaturo, Rabideau, Reilly, San Bento, Savage. Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Watson, Williams, Winfield.

NAYS -0.

The bill marked Substitute "A" is read and passed, as amended, and the original bill indefinitely postponed, on a roll call vote, 88 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 88: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Cambio, Caprio, Carpenter. Carroll, Carter, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey. George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Lopes, Lowe, Maher, Malik, Martineau, McCauley, McNamara. Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

Representative Long requests the journal to reflect that if he had voted on the act, he would have voted in the affirmative.

There is no objection.

Also:

Representative Cicilline requests the Journal to reflect that if he had voted on the act, he would have voted in the affirmative.

There is no objection.

9.(2000-H 8387) An Act relating to retail -licenses to sell alcoholic beverages.

Ordered on the Calendar.

Read and passed, on motion of Representative Inman, seconded by Representative Cicilline, on a roll call vote, 79 members voting in the affirmative and 3 members voting in the negative as follows:

YEAS - 79: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benson, Bramley, Cambio, Caprio, Carpenter, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Maher, Martineau, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Williams, Winfield.

NAYS - 3: Representatives Burlingame, DeSimone, Picard.

10.(00-S 2540 as amended) An Act relating to Long-Term Care Coordinating Council.

Committee on Health, Education and Welfare recommends passage as amended in concurrence.

Read and passed, as amended, in concurrence, on motion of Representative Benoit, seconded by Representatives Shavers, Cicilline and Benson, on a roll call vote, 82 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS 82: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley. Burlingame, Cambio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Lowe, Maher, Malik, Martineau, McCauley, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly. Rose, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Williams, Winfield.

NAYS -0.

11.(00-S 2534 as amended) An Act relating to education - health and safety of pupils.

Committee on Health, Education and Welfare recommends passage as amended in concurrence.

Read and passed, as amended, in concurrence, on motion of Representative Benoit, seconded by Representatives Cambio, Abdullah-Odiase, Shavers and George, on a roll call vote, 81 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 81: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Cambio, Carroll, Carter. Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone. Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally. Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Maher, Martineau, McCauley, McNamara, Menard, Montanaro, Moran,

Moura, Mumford, Munschy, Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Williams, Winfield

NAYS -0.

12.(00-S 2533) An Act relating to health and safety - respiratory care act.

Committee on Health, Education and Welfare recommends passage in concurrence.

Read and passed, in concurrence, on motion of Representative Benoit, seconded by Representatives Martineau, Dennigan, George and Montanaro, on a roll call vote, 84 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 84: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Cambio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Lopes, Lowe, Maher, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Williams, Winfield.

NAYS -0

13.(00-S 2572) (Substitute "A") An Act relating to education- curriculum.

Committee on Health, Education and Welfare recommends indefinite postponement of the original bill and passage of Substitute "A".

Read, and by unanimous consent ordered to be placed on the Calendar for Wednesday, June 28, 2000.

Majority Leader Martineau requests the leave of the House, with the agreement of the Majority and the Minority, to take up the Calendar in order for Wednesday, June 28, 2000.

There is no objection.

CALENDAR

From the Calendar in order for Wednesday, June 28, 2000 are taken:

1.(2000-H 6990) An Act relating to military affairs and defense extension of veteran's benefits.

Joint Committee on Veterans Affairs recommends passage.

Read and passed, on motion of Representative Coderre, seconded by Representatives Carter, Naughton, Simonian, Henseler, Faria, Giannini, Cambio, Benson, Cicilline, Reilly, Lopes, Menard, Moran, Burlingame, Sullivan, Abdullah-Odiase, Iwuc, Munschy, Lanzi, M. Anderson, Kelley, Amaral, Savage and several other members of the House, on a roll call vote, 81 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 81: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Lopes, Lowe, Maher, Martineau, McNamara, Menard, Millard, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

2.

(2000-H 7557) An Act relating to Rhode Island Veterans' Home.

Joint Committee on Veterans Affairs recommends passage.

Read and passed, on motion of Representative Winfield, seconded by Representative Coderre, on a roll call vote, 83 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 83: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello. Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio. Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian. Garvey, George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Lopes. Maher, Martineau, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

3.

(2000-H 7676 as amended) An Act relating to refuse disposal licenses.

Ordered on the Calendar.

Read and passed, as amended, on motion of Representative Dennigan, seconded by Representatives Rose, Garabedian, Mumford, Cambio, Fox and Carter, on a roll call vote, 83 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 83: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Lewiss, Lima, Lowe, Maher, Martineau, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS - 0.

4.(2000-H 7428) House Resolution creating a special House commission to study the use of the internet in state government and to make recommendations therefor.

Committee on Finance recommends passage.

Representative Fox moves passage of the resolution, seconded by Representatives Carter, Cicilline, Benson, Aiken, Slater, Williams, Pires, Ajello and several other members of the House.

Representative Cicilline discusses the resolution.

Read and passed, on a roll call vote, 82 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 82: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Iwuc, Jacquard, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Lopes, Lowe, Maher, Martineau, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento. Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

5.

(2000-H 7995) An Act relating to employment security.

Committee on Finance recommends passage.

Representative Fox moves passage of the act, seconded by Representatives Giannini, Carter, Slater and Moura.

Representative Burlingame discusses the act.

NOW PRESIDING

At 5:17 o'clock P.M., the Honorable Speaker yields the rostrum to the Honorable Deputy Speaker.

CALENDAR

Representative Fox continues to discuss the act.

Read and passed, on a roll call vote, 80 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS 80: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Jacquard, Kelley, Kennedy, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Lopes, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson Williams, Winfield.

NAYS -0.

6.

(2000-H 7998) An Act relating to employment security- administrative funding.

Committee on Finance recommends passage.

Representative Fox moves passage of the act, seconded by Representatives Henseler, Menard, San Bento, Slater and Moura.

Representatives Burlingame, Fox, Abdullah-Odiase, Gorham, Lopes and Garabedian discuss the act.

Read and passed, on a roll call vote, 78 members voting in the affirmative and 3 members voting in the negative as follows:

YEAS - 78: Representatives Abdullah-Odiase, Aiken, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Callahan, Cambio, Caprio, Carpenter, Carter, Cicilline, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Heffner, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Lewiss, Lima, Lopes, Lowe, Martineau, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS - 3: Representatives Burlingame, Gorham, Picard.

TRANSMITTAL

By unanimous consent, all matters on the Clerk's desk are ordered to be transmitted to His Excellency, the Governor, to the Honorable Senate, and to the Honorable Secretary of State, forthwith.

Majority Leader Martineau requests leave of the House, with the agreement of the Majority and the Minority, to take up the Calendar for Thursday, June 29, 2000.

There is no objection.

The Majority Leader discusses the Calendar for the week.

Majority Leader Martineau requests leave of the House to place (00-S 2587 as amended) on tomorrow's Calendar.

There is no objection.

CALENDAR

From the Calendar in order for Thursday. June 29, 2000 are taken:

2.(2000-H 8355) An Act to vacate the forfeiture or revocation of the charter of Westerly Cinema, Inc.

Committee on Corporations recommends passage.

Read and passed, on motion of Representative Kennedy, seconded by Representatives Martineau and Henseler, on a roll call vote, 77 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 77: Representatives Abdullah-Odiase Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr. Benoit, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carter, Coderre, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G., Lima, Long, Lopes, Lowe, Martineau, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires. Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

Representative Lewiss requests the journal to reflect that if he had voted on the Act, he would have voted in the affirmative.

There is no objection.

3.(2000-H 8354) An Act authorizing the town of Charlestown to finance the acquisition, preservation or protection of open space or any interest therein alone or in conjunction with federal agencies, state agencies, land conservancies, land trusts or preservation organizations for preservation, groundwater protection or the development of public recreational facilities in the town by the issuance of not more than $2,000,000 bonds and/or notes therefor.

Committee on Corporations recommends passage.

Read and passed, on motion of Representative Kennedy, seconded by Representatives Martineau, Henseler and Garvey, on a roll call vote, 77 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 77: Representatives Abdullah-Odiase, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Caprio, Carpenter, Carter, Coderre, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Long, Lopes, Lowe, Martineau, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Williams, Winfield.

NAYS -0.

4.

(2000-H 8340) (Substitute "A" as amended) An Act relating to licensing - commercial fishing - licenses.

Committee on Corporations recommends indefinite postponement of the original bill and passage of Substitute "A" as amended.

The bill marked Substitute "A" is read and passed, as amended, and the original bill indefinitely postponed, on motion of Representative caprio, seconded by Representatives Martineau, Henseler, Benson, Lopes, Lally and Palangio, on a roll call vote, 77 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 77: Representatives Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Caprio, Carpenter, Carroll, Carter, Coderre, Corvese, Costantino, Dennigan, DeSimone, maria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Gorham, Henseler, Hogan, Inman,

Iwuc, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Lewiss, Lima, Long, Lopes, Martineau, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson. Williams, Winfield.

NAYS -0.

5.(2000-H 8339) (Substitute "A") An Act relating to waters and navigation - construction of port facilities.

Committee on Corporations recommends indefinite postponement of the original bill and passage of Substitute "A".

The bill marked Substitute "A" is read and passed, and the original bill indefinitely postponed, on motion of Representative Caprio, seconded by Representatives Martineau, Henseler, Benson, Menard, Coderre, Barr, Lally and Palangio, on a roll call vote, 80 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 80: Representatives Abdullah-Odiase Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S.. Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Caprio, Carpenter, Carroll, Carter, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, Giannini, Gorham, Henseler. Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Long, Lopes Lowe, Martineau, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio. Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

6.(00-S 2067) (Substitute "B") An Act relating to businesses and professions home inspectors.

Committee on Corporations recommends indefinite postponement of the original bill and Substitute "A" and passage of Substitute "B".

Representative Kennedy moves passage of the act, seconded by Representatives Rose, Henseler, Menard, Simonian and Moura.

Representatives George, Kennedy, Watson, Montanaro, Palangio, Garabedian, Lowe and Watson discuss the act.

The bill marked Substitute "B" is read and passed, and the original bill and the bill marked Substitute "A" indefinitely postponed, on a roll call vote, 64 members voting in the affirmative and 13 members voting in the negative as follows:

YEAS - 64: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Cambio, Caprio, Carpenter, Carroll, Carter, Cicilline, Coderre, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Henseler, Hogan, Inman, Iwuc, Kennedy, Knickle, Lally, Lanzi, Lewiss, Lima, Lopes, Lowe, Martineau, McNamara, Menard, Moran, Moura, Munschy, Murphy, Naughton, Palangio, Picard, Pires, Pisaturo, Reilly, Rose, San Bento, Schadone, Shavers, Simonian, Slater, Smith, Sullivan, 'Thompson, Winfield.

NAYS 13: Representatives Amaral, Callahan, Costantino, Gorham, Kelley, Millard, Montanaro, Mumford, Palumbo, Rabideau, Savage, Scott, Watson.

(00-S 2911) An Act relating to the motor vehicle reparations act sunset provision.

Committee on Corporations recommends passage in concurrence.

Read and passed, in concurrence, on motion of Representative Kennedy, seconded by Representatives Henseler, Menard, Garvey and Slater, on a roll call vote, 80 members voting in the affirmative and 0 members voting in the

negative as follows:

YEAS - 80: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M.. Anderson, S., Barr, Benoit, Benson, Bramley, .Burlingame, Callahan, Cambio, Caprio, Carpenter, Carroll, Carter, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Lewiss, Lima, Long, Lopes, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS - 0-

8.(00-S 2525) An Act relating to health and safety.

Committee on Corporations recommends passage in concurrence.

Read, and by unanimous consent ordered to be placed on the Calendar for Wednesday, June 28, 2000.

9.(00-S 2340 as amended) An Act relating to public utilities and carriers taxicabs.

Committee on Corporations recommends passage as amended in concurrence.

Read and passed, as amended, in concurrence, on motion of Representative Kennedy, seconded by Representatives Menard and Watson, on a roll call vote, 81 members voting in the affirmative and 1 member voting in the negative as follows:

YEAS - 81: Representatives Abdullah-Odiase. Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carroll, Carter, Cicilline, Coderre. Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy. Kilmartin, Knickle, Lally, Lanzi, Lewiss, Lima, Long, Lopes. Lowe. McNamara, Menard, Millard, Montanaro, Moran Moura. Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento. Savage, Schadone, Scott, Shavers, Sherlock, Simonian. Slater, Smith, Sullivan, Thompson, Vieira, Watson. Williamson, Winfield.

NAYS - 1: Representative Gorham.

10.(00-S 2337) (Substitute "A" An Act relating to financial institutions.

Committee on Corporations recommends indefinite postponement of the original bill and passage of Substitute A in concurrence.

Representative Kennedy moves passage of the act, seconded by Representatives Henseler, Menard, Carter and Kelley.

Representatives Cambio, Kennedy and Costantino discuss the act.

The bill marked Substitute "A" is read and passed, in concurrence, and the original bill indefinitely postponed, on a roll call vote, 82 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 82: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox. Garabedian, Garvey, George, Giannini, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Long, Lopes, Lowe, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Quick, Rabideau, Reilly, Rose, Savage, Schadone, Scott, Shavers,

Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

11.(00-S 2332) An Act relating to financial institutions- lenders and loan brokers.

Committee on Corporations recommends passage in concurrence.

Read and passed, in concurrence, on motion of Representative Kennedy, seconded by Representatives Henseler, Kelley and Menard, on a roll call vote, 81 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 81: The Honorable Speaker Harwood and Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carroll, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Lopes, Lowe, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Quick, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

12.(00-S 2331) An Act relating to businesses and professions- optometrists.

Committee on Corporations recommends passage in concurrence.

Representative Kennedy moves passage of the act, seconded by Representatives Henseler, Menard and Slater.

Representatives Burlingame and Kennedy discuss the act.

Read and passed, in concurrence, on a roll call vote, 76 members voting in the affirmative and 3 members voting in the negative as follows:

YEAS - 76: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Benoit, Benson, Bramley, Callahan, Cambio, Caprio, Carpenter, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan. DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Long, Martineau, McNamara. Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Quick, Rabideau, Reilly, Rose, San Bento, Savage, Schadone. Scott, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams.

NAYS - 3: Representatives Burlingame, Gorham. Lowe.

13.(00-S 2328) An Act relating to community antenna television.

Committee on Corporations recommends passage in concurrence.

Read and passed, in concurrence, on motion of Representative Kennedy, seconded by Representatives Henseler and Menard, on a roll call vote, 81 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 81: Representatives Abdullah-Odiase. Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson 5.. Barr. Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter, Carter, Cicilline, Coderre, Corvese. Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury. Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy. Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lewiss, Lima, Long, Lowe,

Martineau, McNamara, Menard, Millard, Montanaro. Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Quick, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Vieira, Watson, Williams, Winfield.

NAYS -0.

14.(00-S 2325) An Act relating to credit unions.

Committee on Corporations recommends passage in concurrence.

Read and passed, in concurrence, on motion of Representative Kennedy, seconded by Representatives Martineau, Henseler and Slater, on a roll call vote, 73 members voting in the affirmative and 5 members voting in the negative as follows:

YEAS - 73: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter, Carroll, Carter, Cicilline, Coderre, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lima, Long, Lopes, Lowe, Martineau, Menard, Millard, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palumbo, Picard, Pisaturo, Quick, Rabideau, Rose, San Bento, Savage, Schadone, Scott, Shavers, Slater, Smith, Sullivan. Thompson, Vieira, Watson, Williams, Winfield.

NAYS - 5: Representatives George, McNamara, Montanaro, Sherlock, Simonian.

15.(00-S 2323) An Act relating to financial institutions.

Committee on Corporations recommends passage in concurrence.

Read and passed, in concurrence, on motion of Representative Kennedy, seconded by Representatives Martineau, Henseler and Cicilline, on a roll call vote, 82 members voting in the affirmative and 1 member voting in the negative as follows:

YEAS - 82: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox. Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lima, Long, Lopes, Lowe, Martineau, McNamara, Menard, Millard, Moran, Moura, Mumford, Munschy, Naughton, Palangio, Palumbo, Picard, Pires, Pisaturo, Quick, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian. Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS - 1: Representative Murphy.

16.(00-S 2010 as amended) An Act relating to jury lists.

Committee on Corporations recommends passage as amended in concurrence.

Read and passed, as amended, in concurrence, on motion of Representative Kennedy, seconded by Representatives Henseler, Menard and Palangio, on a roll call vote, 75 members voting in the affirmative and 7 members voting in the negative as follows:

YEAS - 75: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson. S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Dennigan, DeSimone, Faria, Flaherty, Fleury, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lima, Long, Lowe, Martineau, Menard, Moran, Moura, Mumford, Munschy. Murphy, Naughton, Palangio, Palumbo, Picard,

Pisaturo, Quick, Rabideau, Rose, Savage, Schadone, Scott, Shavers. Sherlock, Simonian, Slater, Smith, Sullivan. Thompson, Vieira, Watson, Winfield.

NAYS - 7: Representatives Costantino, Fox. Millard, Montanaro, Pires, Reilly, San Bento.

CONSENT CALENDARS

From the Consent Calendar in order for Wednesday, June 28, 2000, are taken:

1.(2000-H 8247) An Act relating to assessment and taxation of new real estate construction in Narragansett.

Committee on Corporations recommends passage.

2.(2000-H 8334) An Act relating to city housing authorities.

Committee on Corporations recommends passage.

3.(2000-H 8317) An Act to vacate the forfeiture or revocation of the charter of TLA Trust, Inc.

Committee on Corporations recommends passage.

4.(2000-H 8335) An Act authorizing the town of Middletown, with the approval of the qualified electors, to issue bonds and notes for the construction, improvement, renovation, furnishing and equipping of library facilities.

Committee on Corporations recommends passage.

5.(00-S 2402) An Act relating to distressed areas - economic revitalization act.

Committee on Corporations recommends passage in concurrence.

6.(00-S 2981) An Act relating to the city of Warwick land trust.

Committee on Corporations recommends passage in concurrence.

7. (00-S 2971) An Act authorizing the town of Jamestown to finance the installation, expansion, construction and improvement of sewers, storm drains, pumping stations and sewage treatment and disposal facilities, to issue not more than $5,500,000 bonds and notes therefor and to impose additional sewer service charges under Chapter 233 of the Public Laws of 1973, as amended, to pay the principal and interest on such bonds and notes.

Committee on Corporations recommends passage in concurrence.

From the Consent Calendar in order for Thursday, June 29, 2000 are taken:

1.(00-S 2177) An Act relating to the Smithfield Land Trust. Committee on Corporations recommends passage in concurrence.

2. (00-S 2886) An Act authorizing the town of South Kingstown to finance the renovation and expansion of buildings and parking facilities at the Town Hall and to issue not more than $1,000,000 bonds therefor.

Committee on Corporations recommends passage in concurrence.

3. (00-S 2899) An Act authorizing the town of South Kingstown to finance the renovation and' or replacement of the roof of the South Road School and to issue not more than $400,000 bonds therefor.

Committee on Corporations recommends passage in concurrence.

4. (00-S 2900) An Act authorizing the town of South Kingstown to finance the acquisition of land for open space, recreation and agricultural purposes and to issue not more than $1,000,000 bonds therefor.

Committee on Corporations recommends passage in concurrence.

5. (00-S 2901) An Act authorizing the town of South Kingstown to finance public works capital improvement projects and to issue not more than $1,000,000 bonds therefor.

Committee on Corporations recommends passage in concurrence.

6. (00-S 2902) An Act authorizing the town of South Kingstown to finance the development and construction of multi-use playfields and park facilities on property located in Green Hill and to issue not more than $600,000 bonds therefor.

Committee on Corporations recommends passage in concurrence.

Read and passed, items 5 through 7 on Wednesday's Calendar and items 1 through 6 on Thursday's Calendar in concurrence, on motion of Representative Henseler, seconded by Representatives Menard and Simonian, and by unanimous consent, on a roll call vote, 80 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 80: Representatives Abdullah-Odiase, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Caprio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Heffner, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lima, Long, Lopes, Lowe, Martineau, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palangio. Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Winfield.

NAYS -0.

COMMUNICATION FROM THE SENATE

A message from the Honorable Senate transmits with announcement of passage, of the following measures:

(2000-H 7011 as amended) An Act relating to housing maintenance and occupancy.

Representative Martineau requests unanimous consent for immediate consideration.

There is no objection.

Read and passed, as amended, in concurrence, on motion of Representative Menard, seconded by Representatives Faria and Carter, and by unanimous consent, on a roll call vote, 79 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 79: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty. Fleury, Fox, Garabedian, Garvey, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, G., Lima, Long, Lopes,

Lowe, Martineau, McNamara, Menard, Montanaro. Moran, Mumford, Munschy, Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Quick, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Simonian, Slater. Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

(2000-H 7139) (Substitute "B") An Act relating to Children, Youth and Families Department.

Representative Martineau requests unanimous consent for immediate consideration.

There is no objection.

Representative Martineau moves passage, seconded by Representatives Benoit. Henseler and Shavers.

Representatives Watson, C. Levesque and Benoit discuss the act.

The bill marked Substitute "B" is read and passed, in concurrence, and the original bill and the bill marked Substitute "A" indefinitely postponed, on a roll call vote, 75 members voting in the affirmative and 1 member voting in the negative as follows:

YEAS - 75: Representatives Abdullah-Odiase. Aiken, Almeida, Anderson, M., Anderson, S., Benoit. Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter. Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garvey. Giannini, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley. Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C.. Levesque, G.. Lewiss, Lima, Long, Lopes, Lowe, Martineau, McNamara, Menard, Millard, Montanaro, Moura, Mumford, Munschy. Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS 1: Representative George.

(2000-H 7562) (Substitute "B,,) An Act relating to automobile excise tax.

Representative Martineau requests unanimous consent for immediate consideration.

There is no objection.

The bill marked Substitute "B" is read and passed, in concurrence, and the original bill and the bill marked Substitute "A" indefinitely postponed, on motion of Representative Martineau, seconded by Representatives Pires and Henseler, and by unanimous consent, on a roll call vote, 77 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS -7: Representatives Abdullah-Odiase, Aiken, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter, Carroll, Carter, Cicilline, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garvey, George, Giannini, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G.. Lewiss, Lima, Long, Lowe, Martineau, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Scott, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS 0.

(2000-H 7750) (Substitute "B" as amended) An Act relating to termination of parental rights.

Representative Martineau requests unanimous consent for immediate consideration.

There is no objection.

The bill marked Substitute "B" is read and passed, as amended, in concurrence, and the original bill and the bill marked Substitute "A" indefinitely postponed, on motion of Representative Martineau, seconded by Representatives Garvey and Henseler, and by unanimous consent, on a roll call vote, 80 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 80: Representatives Abdullah-Odiase, Aiken, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury. Fox, Garabedian, Garvey, George, Giannini, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G., Lewiss, Lima, Long, Lopes, Lowe, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira. Watson, Williams, Winfield.

NAYS -0.

(2000-H 6879) (Substitute "B") An Act relating to business corporations.

Representative Martineau requests unanimous consent for immediate consideration.

There is no objection.

The bill marked Substitute "B" is read and passed, in concurrence, and the original bill and the bill marked Substitute "A" indefinitely postponed, on motion of Representative Martineau, seconded by Representative Henseler, and by unanimous consent, on a roll call vote, 79 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 79: Representatives Abdullah-Odiase, Aiken, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter. Carroll, Cicilline, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey. George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi. Levesque, C., Levesque, G., Lewiss, Lima, Long, Lopes, Lowe, Martineau, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

(2000-H 7613 as amended) An Act relating to health and safety refuse disposal.

Representative Martineau requests unanimous consent for immediate consideration.

There is no objection.

Read and passed, as amended, in concurrence, on motion of Representative Martineau, seconded by Representatives Henseler and Watson, on a roll call vote, 78 members voting in the affirmative and 1 member voting in the negative as follows:

YEAS - 78: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, George, Giannini, Ginaitt, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G., Lima, Long, Lopes, Lowe, Martineau, McCauley, McNamara, Menard, Moran, Moura, Mumford, Munschy, Murphy, Naughton,

Palangio, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Sullivan, Thompson. Vieira, Watson, Williams, Winfield.

NAYS - 1: Representative Montanaro.

(2000-H 6797) (Substitute "A") An Act relating to adjudication of traffic offenses.

Representative Martineau requests unanimous consent for immediate consideration.

There is no objection.

The bill marked Substitute "A" is read and passed, in concurrence, and the original bill indefinitely postponed, on motion of Representative Martineau, seconded by Representatives Henseler and Menard, and by unanimous consent, on a roll call vote, 77 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 77: Representatives Abdullah-Odiase, Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter. Carroll, Carter, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty, Fleury, Fox, Garabedian, Garvey, Gorham, Henseler, Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin, Knickle, Lally, Lanzi, Levesque, C., Levesque, G., Lima, Long, Lopes, Lowe, Martineau, McCauley, McNamara, Menard, Montanaro, Moran, Moura, Mumford, Munschy, Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento. Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

(2000-H 7575) (Substitute "A") An Act relating to domestic assault.

Representative Martineau requests unanimous consent for immediate consideration.

There is no objection.

The bill marked Substitute "A" is read and passed, in concurrence, and the original bill indefinitely postponed, on motion of Representative Martineau, seconded by Representatives Henseler and Burlingame, and by unanimous consent, on a roll call vote, 80 members voting in the affirmative and 0 members voting in the negative as follows:

YEAS - 80: Representatives Abdullah-Odiase. Aiken, Ajello, Almeida, Amaral, Anderson, M., Anderson, S., Barr, Benoit, Benson, Bramley, Burlingame, Callahan, Cambio, Carpenter, Carroll, Carter, Cicilline, Coderre, Corvese, Costantino, Dennigan, DeSimone, Faria, Flaherty. Fox, Garabedian, Garvey, Giannini, Ginaitt, Gorham, Henseler. Hogan, Inman, Iwuc, Kelley, Kennedy, Kilmartin. Knickle, Lally, Lanzi, Levesque, C., Levesque, G., Lima, Long, Lopes, Lowe, Martineau, McCauley, McNamara, Menard, Millard, Montanaro, Moran, Mo':'ra, Mumford, Munschy. Murphy, Naughton, Palumbo, Picard, Pires, Pisaturo, Rabideau, Reilly, Rose, San Bento, Savage, Schadone, Shavers, Sherlock, Simonian, Slater, Smith, Sullivan, Thompson, Vieira, Watson, Williams, Winfield.

NAYS -0.

TRANSMITTAL

By unanimous consent, all matters on the Clerk's desk are ordered to be transmitted to His Excellency, the Governor, to the Honorable Senate, and the Honorable Secretary of State forthwith.

ANNOUNCEMENTS

Majority Leader Martineau announces the desk will be held open in order to receive committee reports to be placed on the Calendar for Friday, June 30, 2000 and by agreement will be moved up.

The Majority Leader announces session for tomorrow and Thursday will be at regular time, 4:00 o'clock P.M. and on Friday, session will convene at 2:00 o'clock P.M.

Also:

Representative Flaherty announces that the Committee on Judiciary will meet today at the rise of the House in Room 205 of the State House.

Also:

Representative Faria announces that the Committee on Labor will meet today at the rise of the House in Room 135 of the State House.

Also:

Representative Kennedy announces that the Committee on Corporations will meet today at the rise of the House in Room 203 of the State House.

ADJOURNMENT

At 5:23 o'clock P.M., on motion of Representative San Bento, and as a further mark of respect to the memory of Herbert Villeneuve; on motion of Representative Carter, and as a further mark of respect to the memory of Frank Quanstrom; on motion of Representative Inman, and as a further mark of respect to the memory of the men and women who served in the Korean War: seconded by Representatives Martineau and Watson, the House adjourns, on a unanimous rising vote.

LINDA McELROY
Recording Clerk

Appendix

INVOCATION

REPRESENTATIVE PETER L. LEWISS

Dear Lord, as this session draws to an end, may we look back over these many weeks and take satisfaction in our accomplishments while at the same time, noting for the future, what we might have done differently. Amen.

Appendix

TRANSMITTED TO THE GOVERNOR

(2000-H 6797) (Substitute "A") An Act relating to adjudication of traffic offenses.

(2000-H 6879) (Substitute "B") An Act relating to business corporations.

(2000-H 7011 as amended) An Act relating to housing maintenance and occupancy.

(2000-H 7139) (Substitute 'B') An Act relating to Children, Youth and Families Department.

(2000-H 7562) (Substitute "B") An Act relating to automobile excise tax.

(2000-H 7575) (Substitute "A") An Act relating to domestic assault.

(2000-H 7613 as amended) An Act relating to health and safety- refuse disposal.

(2000-H 7750) (Substitute "B" as amended) An Act relating to termination of parental rights.

Appendix

FLOOR AMENDMENT

TO
2000 -- H 8360 Substitute A

AN ACT **RELATING TO** HEALTH REFORM, R.I. 2000 -- RITE CARE STABILIZATION, SMALL EMPLOYER INSURANCE REFORM, AND HEALTH INSURERS' ACCOUNTABILITY

Mr. Speaker:

I hereby move to amend 2000 -- H 8360 Substitute A, entitled "AN ACT RELATING TO HEALTH REFORM, R.I. 2000 -- RITE CARE STABILIZATION, SMALL EMPLOYER INSURANCE REFORM, AND HEALTH INSURERS' ACCOUNTABILITY", as follows:

By deleting all of the language following the enactment clause and inserting in place thereof the following:

"SECTION 1. **Intent and purpose.** -- It is the intent of the General Assembly to continue to meet the goals established in 1993 pursuant to section 42-12.3-2 to assure access to comprehensive and quality health care by providing or creating access to affordable health insurance for all Rhode Islanders who are uninsured. Since its establishment in 1994, the RIteCare Program has greatly assisted in making quality health care available to low-income children and their families and pregnant women who otherwise do not have access to health insurance, and has successfully contributed to the overall reduction in the number of Rhode Islanders who are uninsured. However, in establishing and expanding eligibility to the RIteCare Program it was not the intent of the general assembly for the RIteCare Program to replace affordable insurance coverage available through private employer-based health insurance plans. Additionally, instability in the market for health insurance for small employers has contributed to the difficulties faced by employers and employees alike in maintaining affordable employer-based health insurance coverage. The Health Insurance Portability and Accountability Act passed by the United States Congress in 1996 requires additional reform in the small group and individual insurance market. The general assembly finds that:

(1) There has been an erosion in access to affordable employer-based health insurance coverage for low-income working Rhode Islanders, particularly those employed in small businesses.

(2) This decline in affordable employer-based health insurance coverage is due in part to instability in the state's health

insurance market as is evidenced by the economic failure of one of the state's primary health maintenance organizations, the departure of another health insurance provider from the state, a significant increase in the premiums charged by the health insurance issuers remaining in Rhode Island, and growing tensions over the scope and costs of health care between health care insurers and licensed health care practitioners, hospitals and other providers.

(3) The escalating costs of private health coverage have made it difficult for small businesses to offer and contribute to the health insurance coverage of workers and their dependents and remain profitable.

(4) Although employer-based health insurance is no longer affordable for many low-income families, the rate of uninsured in Rhode Island has not increased. Rather, the number of enrollees in RIteCare who have access to employer-based health insurance has increased, and at a much greater rate than anticipated, at least in part because many low-income working families cannot afford to pay the higher premiums.

(5) State expenditures for the RIteCare Program have risen far above anticipated levels, and unless action is taken to improve access to affordable private employer-based plans, the state's ability to meet the goal of assuring access to health insurance coverage for all Rhode Islanders will be undermined.

(6) The 1996 Health Insurance Portability and Accountability Act requires reform of the state's small group and non-group markets. As a result, Rhode Island would gain state control and autonomy over this important economic activity. Additionally, in order to implement the RIteShare Health Insurance Premium Assistance Program in a fiscally responsible manner, stabilization of the small group health market is essential.

Wherefore, it is the intent of the general assembly to utilize state resources in a fair, efficient and economical manner to assist Rhode Islanders of limited means to obtain affordable health insurance by maintaining the RIteCare Program while assisting Rhode Islanders, wherever possible, to continue to utilize available, affordable private employer-based health insurance coverage and to stabilize the insurance market for such coverage. To respond to the disruption caused by the economic failure and withdrawal from Rhode Island of two health maintenance organizations, it is the intent of the general assembly to create new reserve and reporting standards for health plans operating in the state consistent with model standards promulgated by the National Association of Insurance Commissioners.

PART I -- RITECARE STABILIZATION

SECTION 2. Chapter 40-8.4 of the General Laws entitled "Health Care for Families" is hereby amended by adding thereto the following sections:

40-8.4-12. RIteShare Health Insurance Premium Assistance Program. -- (a) Basic RIteShare Health Insurance Premium Assistance Program. The department of human services is authorized and directed to amend the medical assistance Title XIX state plan to implement the provisions of Section 1906 of Title XIX of the Social Security Act and establish the Rhode Island health insurance premium assistance program for RIteCare eligible parents with incomes up to one hundred eighty-five percent (185%) of the federal poverty level who have access to employer-based health insurance. Such state plan amendment shall require eligible individuals with access to employer-based health insurance to enroll themselves and/or their family in such employer-based health insurance plan as a condition of participation in the RIteShare Program under this chapter and as a condition of retaining eligibility for medical assistance under chapters 40-5.1, 40-8.4 and/or 42-12.3 and/or premium assistance under this chapter, provided that doing so meets the criteria established in Section 1906 of Title XIX for obtaining federal matching funds and the department has determined that the individual's and/or the family's enrollment in the employer-based health insurance plan is cost-effective and the department has determined that the employer-based health insurance plan meets the criteria set forth in subsection (d) below. The department shall provide premium assistance by paying all or a portion of the employee's cost for covering the eligible individual or his or her family under the employer-based health insurance plan, subject to the cost sharing provisions in subsection (b), and provided that such premium assistance is cost-effective in accordance with Title XIX.

(b) Individuals who can afford it shall share in the cost. The department of human services is authorized and directed to apply for and obtain any necessary waivers from the Secretary of the United States Department of Health and Human Services, including but not limited to a waiver of the appropriate sections of Title XIX, to require that individuals eligible for RIteCare under chapters 40-8.4 or 42-12.3 with incomes equal to or greater than one hundred fifty percent

(150%) of the federal poverty level pay a share of the costs of health insurance based on the individual's ability to pay, provided that such cost sharing shall not exceed three percent (3%) of the individual's annual income. The department of human services shall implement such cost-sharing by regulation, and shall consider co-payments, premium shares or other reasonable means to do so.

(c) Current RIteCare Enrollees with access to employer-based health insurance. The department of human services shall require any individual who receives RIteCare or whose family receives RIteCare on the effective date of the applicable regulations adopted in accordance with subsection (f) to enroll in an employer-based health insurance plan at the individual's eligibility redetermination date or at an earlier date determined by the department, provided that doing so meets the criteria established in the applicable sections of Title XIX for obtaining federal matching funds and the department has determined that the individual's and/or the family's enrollment in the employer-based health insurance plan is cost-effective and has determined that the health insurance plan meets the criteria in subsection (d) below. The insurer shall accept the enrollment of the individual and/or the family in the employer-based health insurance plan without regard to any enrollment season restrictions.

(d) Approval of health insurance plans for premium assistance. The department of human services shall adopt regulations providing for the approval of employer-based health insurance plans for premium assistance and shall approve such employer-based health insurance plans based on these regulations. In order for an employer-based health insurance plan to gain approval, the department must determine that the benefits offered by the employer-based health insurance plan are substantially similar in amount, scope and duration to the benefits provided to RIteCare eligible persons by the RIteCare Program, when such plan is evaluated in conjunction with available supplemental benefits provided by the department. The department shall obtain and make available to persons otherwise eligible for RIteCare as supplemental benefits those benefits not reasonably available under employer-based health insurance plans which are required for RIteCare eligible persons by state law or federal law or regulation.

(e) Maximization of Federal Contribution. The department of human services is authorized and directed to apply for and obtain federal approvals and waivers necessary to maximize the federal contribution for provision of medical assistance coverage under this section.

(f) Implementation by Regulation. The department of human services is authorized and directed to adopt regulations to ensure the establishment and implementation of the premium assistance program in accordance with the intent and purpose of this section, the requirements of Title XIX and any approved federal waivers.

40-8.4-13. Utilization of Available Employer-Based Health Insurance.-- To the extent permitted under Titles XIX and XXI of the Social Security Act, or by waiver from the Secretary of the U.S. Department of Human Services, the department of human services shall adopt regulations to restrict eligibility for RIteCare under chapters 40-8.4 and/or 42-12.3, or the RIteShare Program under section 40-8.4-12, for certain periods of time for certain individuals or families who have access to, or have refused or terminated employer-based health insurance and for certain periods of time for certain individuals but not including children whose employer has terminated their employer-based health insurance. The department is authorized and directed to amend the medical assistance Title XIX and XXI state plans, and/or to seek and obtain appropriate federal approvals or waivers to implement this section.

40-8.4-14. Permanent Joint Committee on Health Care Oversight. -- (a) The legislature hereby finds and declares that: (1) access to affordable, quality health care is of concern for all Rhode Islanders, (2) the complexities of the health insurance and health care delivery systems result in inefficiencies, confusion and additional costs for consumers and other participants in the health care system, (3) reform to the health insurance and health care delivery systems is achievable only through an ongoing, focused, directed, and informed effort, and (4) steps taken to reduce the numbers of uninsured Rhode Islanders, enhance the quality of care, contain costs, assure accessibility to services, and promote healthy lifestyles should be monitored, adjusted or expanded as needed. Therefore, there is hereby created a permanent legislative committee to monitor, study, report and make recommendations on all areas of health care provision, insurance, liability, licensing, cost and delivery of services, and the adequacy, efficacy and efficiency of statutes, rules, regulations, guidelines, practices, and programs related to health care or health insurance coverage in Rhode Island.

(b) The committee shall consist of eight (8) members of the general assembly: four (4) of whom shall be members of the

house of representatives, three (3) from the majority party and one (1) of whom shall be from the minority party, to be appointed by, and to serve at the discretion of, the speaker of the house of representatives; and four (4) of whom shall be from the senate, three (3) from the majority party and one (1) of whom from the minority party, to be appointed by, and to serve at the discretion of, the senate majority leader.

(c) The committee shall have co-chairpersons, one appointed by the speaker of the house of representatives and one by the senate majority leader.

(d) The committee may review or study any matter related to the provision of health care services that it considers of significance to the citizens of Rhode Island, including the availability of health care, the quality of health care, the effectiveness and efficiency of managed care systems, the efficiency and the operation of state health care programs, and the availability of improved processes or new technologies to achieve more effective and timely resolution of disputes, better communication, speedier, more reliable and less costly administrative processes, claims, payments, and other matters involving the interaction among any or all of government, employers, consumers of health care, providers, health care facilities, insurers and others. The committee may request and shall receive from any health care facility and from any instrumentality of the state, including the department of human services, the department of business regulation, the department of health and department of mental health, retardation, and hospitals, or any other governmental advisory body or commission, including but not limited to, the Governor's Advisory Council on Health, such information and assistance as it deems necessary for the proper execution of its powers and duties under this section, including the annual report of the Governor's Advisory Council on Health.

(e) In addition to the notification regarding regulations required under subsection 40-8.4-10(b), the department of human services shall file with the Permanent Joint Committee on Health Care Oversight a detailed plan for the implementation of the programs created under this chapter by August 1, 2000.

(f) The committee shall have the power to hold hearings, shall meet at least quarterly, may make recommendations to the general assembly, state agencies, private industry or any other entity, and shall report to the general assembly on its findings and recommendations as it determines appropriate.

40-8.4-15. Advisory Commission on Health Care. -- (a) There is hereby established an advisory commission to be known as the Advisory Commission on Health Care to advise the director of the department of human services on all matters relating to the RIteCare and RIteShare Programs, and other matters concerning access for all Rhode Islanders to quality health care in the most affordable, economical manner. The director of the department of human services shall serve ex officio as chairperson. The director shall appoint the eighteen (18) members:

(1) three (3) of whom shall represent the health care providers;

(2) three (3) of whom shall represent the health care insurers;

(3) three (3) of whom shall represent health care consumers or consumer organizations;

(4) two (2) of whom shall represent organized labor;

(5) one (1) of whom shall be the health care advocate in the office of the attorney general;

(6) three (3) of whom shall represent employers; and

(7) three (3) of whom shall be other members of the public.

(b) The commission may study all aspects of the provisions of the RIteCare and RIteShare Programs involving purchasers of health care, including employers, consumers and the state, health insurers, providers of health care, and health care facilities, and all matters related to the interaction among these groups, including methods to achieve more effective and timely resolution of disputes, better communication, speedier, more reliable and less costly administrative processes, claims, payments, and other reimbursement matters, and the application of new processes or technologies to such issues.

(c) Members of the commission shall be appointed in the month of July, each to hold office until the last day of June in the second year of his or her appointment or until his or her successor is appointed by the director.

(d) The commission shall meet at least quarterly, and the initial meeting of the commission shall take place on or before September 15, 2000. The commission may meet more frequently than quarterly at the call of the chair or at the call of any three (3) members of the commission.

(e) Members of the Permanent Joint Committee on Health Care Oversight established pursuant to section 40-8.4-14 shall be notified of each meeting of the commission and shall be invited to participate.

SECTION 3. Sections 40-8.4-4, 40-8.4-7 and 40-8.4-10 of the General Laws in Chapter 40-8.4 entitled "Health Care For Families" are hereby amended to read as follows:

40-8.4-4. Eligibility. -- (a) Medical assistance for families. - There is hereby established a category of medical assistance eligibility pursuant to section 1931 of title XIX of the Social Security Act [42 U.S.C. section 1396u-1] for families whose income and resources are no greater than the standards in effect in the aid to families with dependent children program on July 16, 1996 or such increased standards as the department may determine. The department of human services is directed to amend the medical assistance title XIX state plan and to submit to the U.S. Department of Health and Human Services an amendment to the RIte Care waiver project to provide for medical assistance coverage to families under this chapter in the same amount, scope and duration as coverage provided to comparable groups under the waiver. The department is further authorized and directed to submit such amendments and/or requests for waivers to the title XXI state plan as may be necessary to maximize federal contribution for provision of medical assistance coverage under this chapter. However, implementation of expanded coverage under this chapter shall not be delayed pending federal review of any title XXI amendment or waiver.

(b) Income. - The director of the department of human services is authorized and directed to amend the medical assistance title XIX state plan or RIte Care waiver to provide medical assistance coverage through expanded income disregards or other methodology for families whose income levels are below one hundred eighty-five percent (185%) of the federal poverty level.

(c) Resources. - Resources shall be disregarded in determining eligibility under this chapter.

(d) Waiver. - The department of human services is authorized and directed to apply for and obtain appropriate waivers from the Secretary of the U.S. Department of Health and Human Services, including, but not limited to, a waiver of the appropriate provisions of Title XIX, to require that individuals with incomes equal to or greater than one hundred fifty percent (150%) of the federal poverty level pay a share of the costs of their medical assistance coverage provided through enrollment in either the RIteCare Program or under the premium assistance program under section 40-8.4-12, in a manner and at an amount consistent with comparable cost-sharing provisions under section 40-8.4-12, provided that such cost sharing shall not exceed three percent (3%) of annual adjusted income.

40-8.4-7. Buy-In. -- The Department of Human Services shall investigate and develop opportunities for individuals and/or employers to buy into, at the individual's and/or employer's expense, one or more programs the department may establish under this chapter or chapter 12.3 of title 42 to address uninsurance among Rhode Islanders, and shall provide a report on such efforts to the Permanent Joint Committee on Health Care Oversight established pursuant to section 40-8.4-14 on or before February 15 of each year.

~~The department of human services shall establish a plan to be submitted to the general assembly for approval by April 1, 2000, for enrollment fees, deductibles, co-payments and/or other contributions based on ability to pay, and in such manner to assure access to programs established under this section for all Rhode Islanders.~~

40-8.4-10. Regulations. - (a) The department of human services is authorized to promulgate any regulations necessary to implement this chapter.

(b) When promulgating any rule or regulation necessary to implement this chapter or any rule or regulation related to

RIteCare, the department shall send the notice referred to in section 42-35-3 and a true copy of the rule referred to in section 42-35-4 of the Rhode Island Administrative Procedure Act to each of the co-chairpersons of the Permanent Joint Committee on Health Care Oversight established by section 40-8.4-14.

PART II -- SMALL GROUP REFORM

SECTION 4. Title 27 of the general laws entitled "Insurance" is hereby amended by adding thereto the following chapters:

CHAPTER 18.5
INDIVIDUAL HEALTH INSURANCE COVERAGE

27-18.5-1. Purpose. -- To insure compliance of all policies, contracts, certificates and agreements of individual health insurance coverage offered or delivered in this state with the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

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

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

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

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

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

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

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

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

(vii) has a constitution and bylaws; and

(viii) meets such additional requirements as the director may prescribe by regulation.

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

(i) Section 4980B of the Internal Revenue Code of 1986, other than the subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(ii) Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974, other than Section 609 of such act.

(iii) Title XXII of the United States Public Health Service Act.

(3) "Creditable coverage" has the same meaning as defined in the United States Public Health Service Act, Section 2701(c), as amended by P.L. 104-191.

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

(5) "Eligible individual" means an individual:

(i) For whom, as of the date on which the individual seeks coverage under this chapter, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, a governmental plan established or maintained for its employees by the government of the United States or by any of its agencies or instrumentalities, or church plan (as defined by the Employee Retirement Income Security Act of 1974);

(ii) Who is not eligible for coverage under a group health plan, part A or part B of title XVIII of the Social Security Act, or any state plan under title XIX of the Social Security Act (or any successor program), and does not have other health insurance coverage;

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

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

(v) Who, if the individual elected such COBRA continuation coverage, has exhausted such continuation coverage under such provision or program.

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

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

"Health insurance coverage" shall not include one or more, or any combination of, the following:

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

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

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

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

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

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

"Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

(i) Limited scope dental or vision benefits;

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

thereof;

(iii) Such other similar, limited benefits as are specified in federal regulation issued pursuant to P.L. 104-191.

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

"Health insurance coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882 (g) (1) of the Social Security Act;

(ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

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

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

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

(i) Health status;

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

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

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

(viii) Disability.

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

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

(12) "Preexisting condition" means, with respect to health insurance coverage, a condition (whether physical or mental), regardless of the cause of the condition, that was present before the date of enrollment for such coverage, for which

medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period ending on the enrollment date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

27-18.5-3. Guaranteed availability to certain individuals. -- (a) Notwithstanding any of the provisions of this title to the contrary, all health insurance carriers that offer health insurance coverage in the individual market in this state shall provide for the guaranteed availability of coverage to an eligible individual or an individual who has health insurance coverage continuously for at least twelve (12) consecutive months and who applies for coverage in the individual market no later than sixty-three (63) days following termination of such coverage, desiring to enroll in individual health insurance coverage, and may not:

(1) decline to offer such coverage to, or deny enrollment of, such individual; or

(2) impose any preexisting condition exclusion with respect to such coverage.

(b) All health insurance carriers that offer health insurance coverage in the individual market in this state shall offer all policy forms of health insurance coverage. Provided, however, the carrier may elect to limit the coverage offered so long as it offers at least two (2) different policy forms of health insurance coverage (policy forms which have different cost-sharing arrangements or different riders shall be considered to be different policy forms) both of which:

(1) are designed for, made generally available to, and actively market to, and enroll both eligible and other individuals by the carrier; and

(2) meet the requirements of subparagraph (i) or (ii) as elected by the carrier:

(i) if the carrier offers the policy forms with the largest, and next to the largest, premium volume of all such policy forms offered by the carrier in this state; or

(ii) if the carrier offers a choice of two (2) policy forms with representative coverage, consisting of a lower-level coverage policy form and a higher-level coverage policy form each of which includes benefits substantially similar to other individual health insurance coverage offered by the carrier in this state and each of which is covered under a method that provides for risk adjustment, risk spreading, or financial subsidization.

For the purposes of this subsection, "lower-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least eighty-five percent (85%) but not greater than one hundred percent (100%) of the policy form weighted average.

For the purposes of this subsection, "higher-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least fifteen percent (15%) greater than the actuarial value of lower-level coverage offered by the carrier in this state, and the actuarial value of the benefits under the coverage is at least one hundred percent (100%) but not greater than one hundred twenty percent (120%) of the policy form weighted average.

For the purposes of this subsection, "policy form weighted average" means the average actuarial value of the benefits provided by all the health insurance coverage issued (as elected by the carrier) either by that carrier or, if such data are available, by all carriers in this state in the individual market during the previous year (not including coverage issued under this subsection), weighted by enrollment for the different coverage. The actuarial value of benefits shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

The carrier elections under this subsection shall apply uniformly to all eligible individuals in this state for that carrier. Such an election shall be effective for policies offered during a period of not shorter than two (2) years.

(c) A carrier may deny health insurance coverage in the individual market to an eligible individual if the carrier has demonstrated to the director that:

(1) it does not have the financial reserves necessary to underwrite additional coverage; and

(2) it is applying this subsection uniformly to all individuals in the individual market in this state consistent with applicable state law and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

A carrier upon denying individual health insurance coverage in this state in accordance with this subsection may not offer such coverage in the individual market in this state for a period of one hundred eighty (180) days after the date such coverage is denied or until the carrier has demonstrated to the director that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later.

(d) Nothing in this section shall be construed to require that a carrier offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

(e) A carrier offering health insurance coverage in connection with group health plans under this title shall not be deemed to be a health insurance carrier offering individual health insurance coverage solely because such carrier offers a conversion policy.

(f) Nothing in this section shall be construed to create additional restrictions on the amount of premium rates that a carrier may charge an individual for health insurance coverage provided in the individual market; or to prevent a health insurance carrier offering health insurance coverage in the individual market from establishing premium rates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(g) In the case of a health insurance carrier that offers health insurance coverage in the individual market through a network plan, the carrier may limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service areas for such network plan; and within the service areas of such plan, deny coverage to such individuals if the carrier has demonstrated to the director that:

(1) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees; and

(2) it is applying this subsection uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

Upon denying health insurance coverage in any service area in accordance with the terms of this subsection, a carrier may not offer coverage in the individual market within such service area for a period of one hundred eighty (180) days after such coverage is denied.

27-18.5-4. Continuation of coverage -- Renewability. -- (a) A health insurance carrier that provides individual health insurance coverage to an individual in this state shall renew or continue in force such coverage at the option of the individual.

(b) A health insurance carrier may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) the individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the carrier has not received timely premium payments;

(2) the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) the carrier is ceasing to offer coverage in accordance with subsections (c) and (d) below;

(4) in the case of a carrier that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the carrier is authorized to do business) but

only if such coverage is terminated hereunder uniformly without regard to any health status-related factor of covered individuals; or

(5) in the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated hereunder uniformly and without regard to any health status-related factor of covered individuals.

(c) In any case in which a carrier decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued only if:

(1) the carrier provides notice, to each covered individual provided coverage of this type in such market, of such discontinuation at least ninety (90) days prior to the date of discontinuation of such coverage;

(2) the carrier offers to each individual in the individual market provided coverage of this type, the opportunity to purchase any other individual health insurance coverage currently being offered by the carrier for individuals in such market; and

(3) in exercising this option to discontinue coverage of this type and in offering the option of coverage under paragraph (2) above, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(d) In any case in which a carrier elects to discontinue offering all health insurance coverage in the individual market in this state, health insurance coverage may be discontinued only if:

(1) the carrier provides notice to the director and to each individual of such discontinuation at least one hundred eighty (180) days prior to the date of the expiration of such coverage; and

(2) all health insurance issued or delivered in this state in such market is discontinued and coverage under this health insurance coverage in such market is not renewed.

(e) In the case of a discontinuation under subsection (d) above, the carrier may not provide for the issuance of any health insurance coverage in the individual market in this state during the five (5) year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(f) The provisions of subsections (d) and (e) above shall not apply if, at the time of coverage renewal, a health insurance carrier modifies the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is otherwise consistent with this chapter and other applicable law and effective on a uniform basis among all individuals with that policy form.

(g) In applying this section in the case of health insurance coverage that is made available by a carrier in the individual market to individuals only through one (1) or more associations, a reference to an "individual" is deemed to include a reference to such an association (of which the individual is a member).

27-18.5-5. Enforcement -- Limitation on actions. -- The director shall have the power to enforce the provisions of this chapter in accordance with section 42-14-16 and all other applicable laws.

27-18.5-6. Rules and regulations. -- The director may promulgate rules and regulations necessary to effectuate the purposes of this chapter.

27-18.5-7. Severability. -- If any provision of this chapter, or the application thereof to any person or circumstances is for any reason held invalid, the remainder of the chapter and the application of that provision to other persons or circumstances shall not be affected thereby.

CHAPTER 18.6

LARGE GROUP HEALTH INSURANCE COVERAGE

27-18.6-1. Purpose. -- To insure compliance of all policies, contracts, certificates and agreements of group health insurance coverage offered or delivered in this state with the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

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

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

(2) "Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Security Act of 1974.

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

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

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

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

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

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

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

(vii) has a constitution and bylaws; and

(viii) meets such additional requirements as the director may prescribe by regulation.

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

(i) Section 4980B of the Internal Revenue Code of 1986, other than the subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(ii) Part 6 of subtitle B of title 1 of the Employee Retirement Income Security Act of 1974, other than section 609 of such act.

(iii) Title XXII of the United States Public Health Service Act.

(5) "Creditable coverage" has the same meaning as defined in the United States Public Health Service Act, section 2701(c), as amended by P.L. 104-191.

(6) "Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

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

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

(9) "Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(10) "Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term shall include only employers of two (2) or more employees.

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

(12) "Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and includes any governmental plan established or maintained for its employees by the government of the United States, the government of any state or political subdivision thereof or by any agency or instrumentality of such government.

(13) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(14) "Group health plan" means an employee welfare benefits plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

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

"Health insurance coverage" shall not include one (1) or more, or any combination of, the following "excepted benefits":

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

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

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

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

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

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

"Health insurance coverage" shall not include the following "limited, excepted benefits" if they are provided under a separate policy, certificate of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

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

thereof;

(iii) Such other similar, limited benefits as are specified in federal regulations issued pursuant to P.L. 104-191.

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

"Health insurance coverage" shall not include the following "supplemental, excepted benefits" if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); and

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

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

(17) "Health maintenance organization" ("HMO") means a health maintenance organization licensed under chapter 41 of this title.

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

(i) Health status;

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

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

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

(viii) Disability.

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

days in the current calendar year.

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

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

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

(ii) a special enrollment period.

(22) "Medical care" means amounts paid for:

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

(ii) amounts paid for transportation primarily for and essential to medical care referred to in (i) above; and

(iii) amounts paid for insurance covering medical care referred to in (i) and (ii) above.

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

(24) "Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(25) "Placed for adoption" means, in connection with any placement for adoption of a child with any person, the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(26) "Plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974. "Plan sponsor" shall also include any bona fide association, as defined in this section 27-18.6-2.

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

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

27-18.6-3. Limitation on preexisting condition exclusion. -- (a) Notwithstanding any of the provisions of this title to the contrary, a group health plan and a health insurance carrier offering group health insurance coverage shall not deny, exclude, or limit benefits with respect to a participant or beneficiary because of a preexisting condition exclusion except if:

(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date.

(2) such exclusion extends for a period of not more than twelve (12) months (or eighteen (18) months in the case of a late enrollee) after the enrollment date; and

(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or the beneficiary as of the enrollment date.

For purposes of this section, genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

(b) With respect to subsection (a)(3), a period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a sixty-three (63) day period during which the individual was not covered under any creditable coverage.

(c) Any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance or is in an affiliation period shall not be taken into account in determining the continuous period under subsection (b).

(d) Except as otherwise provided in subsection (e) below, for purposes of applying subsection (a)(3), a group health plan and a health insurance carrier offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(e) A group health plan or a health insurance carrier offering group health insurance may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits. Such classes or categories of benefits are to be determined by the secretary of the United States department of health and human services pursuant to regulation. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election, a group health plan or carrier shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

In the case of an election hereunder with respect to a group health plan (whether or not health insurance coverage is provided in connection with such plan), the plan shall:

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee under the plan, that the plan has made such election; and

(ii) include in such statements a description of the effect of this election.

In the case of an election hereunder with respect to health insurance coverage offered by a carrier in the large group market, the carrier shall:

(i) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the carrier has made such election; and

(ii) include in such statements a description of the effect of such election.

(f) A group health plan and a health insurance carrier offering group health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty (30) day period beginning with the date of birth, is covered under creditable coverage.

This provision shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any creditable coverage. Moreover, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period for purposes of determining creditable coverage.

(g) A group health plan and a health insurance carrier offering group health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, as of the last day of the thirty (30) day period beginning on the date of the adoption or

placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

This provision shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any creditable coverage. Moreover, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period for purposes of determining creditable coverage.

(h) A group health plan and a health insurance carrier offering group health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(i) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications. A group health plan and a health insurance carrier offering group health insurance coverage shall provide certifications:

(1) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(2) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such a provision; and

(3) on the request of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subsection (1) or (2) above, whichever is later.

The certification under subsection (i) of this section may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

The certification described in subsection (i) is a written certification of:

(1) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision; and

(2) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this subsection if the health insurance carrier offering the coverage provides for such certification in accordance with this subsection.

In the case of an election taken pursuant to subsection (e) above by a group health plan or a health insurance carrier, if the plan or carrier enrolls an individual for coverage under the plan and the individual provides a certification of creditable coverage, upon request of the plan or carrier, the entity which issued the certification shall promptly disclose to the requisition plan or carrier information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and such entity may charge the requesting plan or carrier for the reasonable cost of disclosing such information.

Failure of an entity to provide information under this subsection with respect to previous coverage of an individual so as to adversely affect any subsequent coverage of the individual under another group health plan or health insurance coverage, as determined in accordance with rules and regulations established by the secretary of the United States department of health and human services, shall be a violation of this chapter.

(j) A group health plan and a health insurance carrier offering group health insurance coverage in connection with a group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions are met:

(1) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(2) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or carrier (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(3) The employee's or dependent's coverage described in subsection (j)(1) above:

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

(4) Under the terms of the plan, the employee requests such enrollment not later than thirty (30) days after the date of exhaustion of coverage described in paragraph (3)(i) above or termination of coverage or employer contribution described in paragraph (3)(ii) above.

(k) If a group health plan makes coverage available with respect to a dependent of an individual, the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and a person becomes such a dependent of the individual through marriage, birth, or adoption or placement through adoption, the group health plan shall provide for a dependent special enrollment period during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

A dependent special enrollment period shall be a period of not less than thirty (30) days and shall begin on the later of:

(1) the date dependent coverage is made available; or

(2) the date of the marriage, birth, or adoption or placement for adoption (as the case may be).

If an individual seeks to enroll a dependent during the first thirty (30) days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(1) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(2) in the case of a dependent's birth, as of the date of such birth; or

(3) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(l) A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) above with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if such period is applied uniformly without regard to any health status-related factors, and such period does not exceed two (2) months (or three (3) months in the case of a late enrollee).

For the purposes hereof, "such period" shall begin on the enrollment date.

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

The director may approve alternative methods from those described under subsection (1) to address adverse selection.

(m) For the purpose of determining creditable coverage pursuant to this chapter, no period before July 1, 1996 shall be taken into account. However, individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for the prohibition in the preceding sentence may be given credit for creditable coverage for such periods through the presentation of documents or other means in accordance with any rule or regulation that may be established by the secretary of the United States department of health and human services.

(n) Subject to subsection (m) above, subsection (i) above shall apply to events occurring after June 30, 1996. In no case shall a certification required under subsection (i) of this section be required to be provided before June 1, 1997.

In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under subsection (i) above unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because is relates to an event occurring before June 30, 1996, the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage. The group health plan and a health insurance carrier shall not be subject to any penalty or enforcement action with respect to the plan's or carrier's crediting (or not crediting) such coverage if the plan or carrier has sought to comply in good faith with the applicable requirements hereof.

27-18.6-4. Discrimination prohibited. -- (a) Notwithstanding any of the provisions of this title to the contrary, a group health plan and a health insurance carrier offering group health insurance in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on health status-related factors in relation to the individual or dependent of the individual.

Rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) Subsection (a) above shall not be construed:

(1) to require a group health plan or group health insurance coverage to provide particular benefits other than those provided under the terms of such plan or coverage; or

(2) to prevent such a plan or coverage from establishing limitations on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the coverage.

(c) A group health plan and a health insurance carrier offering health insurance coverage in connection with a group health plan may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as dependent of the individual.

Nothing contained within this subsection (c) shall be construed to:

(1) restrict the amount that an employer may be charged for coverage under a group health plan; or

(2) prevent a group health plan and a health insurance carrier offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

27-18.6-5. Continuation of coverage -- Renewability. -- (a) Notwithstanding any of the provisions of this title to the contrary, a health insurance carrier that offers health insurance coverage in the large group market in this state in connection with a group health plan shall renew or continue in force such coverage at the option of the plan sponsor of the plan.

(b) A health insurance carrier may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the large group market based only on one or more of the following:

(1) the plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the carrier has not received timely premium payments;

(2) the plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted by the director pursuant to rule or regulation;

(4) the carrier is ceasing to offer coverage in accordance with subsections (c) and (d) below;

(5) the director finds that the continuation of the coverage would:

(i) not be in the best interests of the policyholders or certificate holders; or

(ii) impair the carrier's ability to meet its contractual obligations;

(6) in the case of a health insurance carrier that offers health insurance coverage in the large group market through a network plan, there is no longer any enrollee in connection with such plan who resides, lives, or works in the service area of the carrier (or in an area for which the carrier is authorized to do business); and

(7) in the case of health insurance coverage that is made available in the large group market only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated under this section uniformly without regard to any health status-related factor relating to any covered individual.

(c) In any case in which a carrier decides to discontinue offering a particular type of group health insurance coverage offered in the large group market, and the director finds that that product form is obsolete and is being replaced with comparable coverage, coverage of such type may be discontinued by the carrier only if:

(1) the carrier provides advance notice of its decision to the insurance commissioner in each state in which it is licensed;

(2) the carrier provides notice of the decision to all affected plan sponsors, participants and beneficiaries, and to the insurance commissioner in each state in which an affected insured individual is known to reside at least one hundred eighty (180) days prior to the date of discontinuation of such coverage. Notice to the insurance commissioner shall be provided at least three (3) working days prior to the notice to the affected plan sponsors, participants and beneficiaries;

(3) the carrier offers to each plan sponsor provided coverage of this type in the large group market, the option to purchase any other health insurance coverage currently being offered by the carrier to a group health plan in such market; and

(4) in exercising this option to discontinue coverage of this type and in offering the option of coverage under paragraph (3) above, the carrier acts uniformly without regard to the claims experience of those plan sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(d) In any case in which a carrier elects to discontinue offering and to nonrenew all of its health insurance coverage in the large group market in this state, the carrier shall:

(1) provide advance notice to the director, to the insurance commissioner in each state in which the carrier is licensed, and to each plan sponsor (and participants and beneficiaries covered under such coverage and to the insurance commissioner in each state in which an affected insured individual is known to reside) of such decision at least one

hundred eighty (180) days prior to the date of the discontinuation of such coverage. Notice to the insurance commissioner shall be provided at least three (3) working days prior to the notice to the affected plan sponsors, participants and beneficiaries; and

(2) discontinue all health insurance issued or delivered for issuance in this state's large group market and not renew coverage under any health insurance coverage issued to a large employer.

(e) In the case of a discontinuation under subsection (d) above, the carrier shall be prohibited from the issuance of any health insurance coverage in the large group market in this state for a period of five (5) years from the date of notice to the director.

(f) At the time of coverage renewal, a health insurance carrier may modify the health insurance coverage for a product offered to a group health plan in the large group market.

(g) In applying this section in the case of health insurance coverage that is made available by a carrier in the large group market to employers only through one or more associations, a reference to a "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

27-18.6-6. Applicability -- Exclusion of certain plans. -- (a) The requirements of this chapter shall not apply to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan does not meet the definition of large employer and is thereby subject to the provisions of chapter 50 of this title.

(b) The requirements of this chapter shall apply with respect to group health plans only:

(1) in the case of a plan that is a nonfederal governmental plan; and

(2) with respect to group health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan).

If the plan sponsor of a nonfederal governmental plan which is a group health plan to which this chapter otherwise applies makes an election (in such form and manner as the secretary of the United States department of health and human services may prescribe by regulation), then the requirements hereof insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided herein.

Such an election shall apply for a single specified plan year (which may be extended through subsequent elections), or in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement.

Under the foregoing election, the plan shall provide for notice to enrollee (on an annual basis and at the time of enrollment under the plan) of the fact and consequences of such election, and certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with section 27-18.6-3(i).

(c) The requirements of this chapter shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of limited, excepted benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan.

(d) The requirements of this chapter shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of noncoordinated, excepted benefits if all of the following conditions are met:

(1) the benefits are provided under a separate policy, certificate, or contract of insurance.

(2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(3) such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(e) The requirements of this chapter shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of supplemental, excepted benefits if the benefits are provided under a separate policy, certificate, or contract of insurance.

(f) For purposes of this chapter, any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund or program), directly or through insurance, reimbursement, or otherwise, shall be treated as an employee welfare benefit plan which is a group health plan.

In the case of a group health plan, the term "employer" also includes the partnership in relation to any partner.

In the case of a group health plan, the term "participant" also includes:

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

(2) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual, if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefits.

27-18.6-7. Collective bargaining agreements. -- Notwithstanding anything contained in this chapter to the contrary, except as provided in section 27-18.6-3(n), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this chapter shall not apply to plan years beginning before the later of:

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this chapter); or

(2) July 1, 1997.

For purposes of paragraph (1), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement hereof shall not be treated as a termination of such collective bargaining agreement.

27-18.6-8. Enforcement -- Limitation on actions. -- The director shall have the power to enforce the provisions of this chapter in accordance with section 42-14-16 and all other applicable state law.

27-18.6-9. Rules and regulations. -- The director may promulgate rules and regulations necessary to effectuate the purposes of this chapter.

27-18.6-10. Severability. -- If any provision of this chapter, or the application thereof to any person or circumstances is for any reason held invalid, the remainder of the chapter and the application of that provision to other persons or circumstances shall not be affected thereby.

SECTION 5. Section 27-18-37 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" is hereby repealed.

~~**27-18-37. Prohibit policies/plans that utilize pre-existing conditions clauses. --** Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state on or after January 1, 1996, except for supplemental policies which only provide~~

~~coverage for specified diseases, or other supplemental policies, shall not contain any clause that would limit coverage for any pre-existing condition, nor shall any pre-existing condition be used as a basis for denying the issuance of a policy for any individual who has been continuously insured or covered for the period of twelve (12) months immediately prior to their date of application for insurance or coverage, which previous insurance or coverage provided for the payment of benefits for the condition which is pre-existing. Individuals seeking insurance or coverage must provide to the accident and sickness policy insurer documentation of twelve (12) months of continuous insurance or coverage.~~

~~Nothing contained in this section shall be deemed to apply to supplemental policies which only provide coverage for specified diseases or other supplemental policies.~~

SECTION 6. Section 27-19-33 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby repealed.

~~**27-19-33. Prohibit policies/plans that utilize pre-existing conditions clauses --** Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state on or after January 1, 1996, shall not contain any clause that would limit coverage for any pre-existing condition, nor shall any pre-existing condition be used as a basis for denying the issuance of a policy for any individual who has been continuously insured or covered for the period of twelve (12) months immediately prior to their date of application for insurance or coverage, which previous insurance or coverage provided for the payment of benefits for the condition which is pre-existing. Individuals seeking insurance or coverage must provide to the accident and sickness policy insurer documentation of twelve (12) months of continuous insurance or coverage.~~

SECTION 7. Section 27-20-28 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby repealed in its entirety.

~~**27-20-28. Prohibit policies/plans that utilize pre-existing conditions clauses --** Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state on or after January 1, 1996, shall not contain any clause that would limit coverage for any pre-existing condition, nor shall any pre-existing condition be used as a basis for denying the issuance of a policy for any individual who has been continuously insured or covered for the period of twelve (12) months immediately prior to their date of application for insurance or coverage, which previous insurance or coverage provided for the payment of benefits for the condition which is pre-existing. Individuals seeking insurance or coverage must provide to the accident and sickness policy insurer documentation of twelve (12) months of continuous insurance or coverage.~~

SECTION 8. Section 27-41-42 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby repealed in its entirety.

~~**27-41-42. Prohibit policies/plans that utilize pre-existing conditions clauses --** Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical service plan contract delivered, issued for delivery or renewed in this state on or after January 1, 1996, shall not contain any clause that would limit coverage for any pre-existing condition, nor shall any pre-existing condition be used as a basis for denying the issuance of a policy for any individual who has been continuously insured or covered for the period of twelve (12) months immediately prior to their date of application for insurance or coverage, which previous insurance or coverage provided for the payment of benefits for the condition which is pre-existing. Individuals seeking insurance or coverage must provide to the accident and sickness policy insurer documentation of such twelve (12) month continuous insurance or coverage.~~

SECTION 9. Sections 27-50-1, 27-50-2, 27-50-3, 27-50-4, 27-50-7, 27-50-8, 27-50-9, 27-50-10, 27-50-11, 27-50-12, 27-50-13, 27-50-14, 27-50-15, 27-50-16 and 27-50-17 of the General Laws in Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" are hereby repealed in their entirety. Sections 27-50-5 and 27-50-6 of the General Laws in Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" are repealed in their entirety effective October 1, 2000.

~~**27-50-1. Short title --** This chapter shall be known and may be cited as the "Small Employer Health Insurance Availability Act".~~

27-50-2. Purpose -- (a) The purpose and intent of this chapter are to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for development of "economy" and "standard" health benefit plans to be offered to all small employers, to provide for the establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

(b) This chapter is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

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

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

(c) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(d) "Board" means the board of directors of the program established in section 27-50-11.

(e) "Carrier" means any entity that provides health insurance in this state. For the purposes of this chapter, carrier includes an insurance company, a nonprofit hospital and/or medical service corporation, a fraternal benefit society, a health maintenance organization, as defined in chapter 41 of this title or as defined in chapter 62 of title 42, or any other entity providing a plan of health insurance subject to state insurance regulation.

(f) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status, and duration of coverage shall not be case characteristics for the purposes of this chapter.

(g) "Class of business" means all or a grouping of small employers established pursuant to section 27-50-5.

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

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

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

(k) "Economy health benefit plan" means the lower cost health benefit plan described in section 27-50-12.

(l) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part time, temporary, or substitute basis.

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

(n) "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service corporation subscriber contract, or health maintenance organization subscriber contract. "Health benefit plan" does not include accident only, credit, dental, vision, Medicare supplement, specified disease, fixed indemnity, other limited benefit policies, long term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical-payment insurance.

(o) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(p) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period for which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(1) The individual meets each of the following:

(i) The individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse; or divorce; and

(iii) The individual requests enrollment within thirty (30) days after the termination of the qualifying previous coverage;

(2) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

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

(q) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(r) "Plan of operation" means the plan of operation of the program established pursuant to section 27-50-11.

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

(t) "Producer" means any insurance producer licensed under chapter 2.3 of this title.

(u) "Program" means the small group reinsurance program created pursuant to section 27-50-11.

(v) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(1) Medicare or Medicaid;

(2) An employer based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the economy health benefit plan; or

(3) An individual health insurance policy issued by a carrier that provides benefits similar to or exceeding the benefits provided under the economy health benefit plan, provided that the policy has been in effect for a period of at least one year.

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

(x) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to section 27-50-11.

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

(z) "Risk-assuming carrier" means a small employer carrier whose application is approved by the director pursuant to section 27-50-10.

(aa) "Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business, including but not limited to a business or a corporation organized under the Rhode Island Nonprofit Corporation Act or a similar act of another state that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty (50) eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

(bb) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

(cc) "Standard health benefit plan" means the standard health benefit plan described in section 27-50-12.

27-50-4. Applicability and scope -- This chapter applies to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(1) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of 26 U.S.C. section 162, 125 or 106; and

(4) (i) Except as provided in subsection (4)(ii) for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier;

(ii) An affiliated carrier that is a health maintenance organization having a license under chapter 41 of this title or a health maintenance organization as defined in chapter 62 of title 42 may be considered to be a separate carrier for the purposes of this chapter;

(iii) Unless otherwise authorized by the director, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if those arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for the health benefit plans being retained by the ceding carrier. The department of business regulation's statutory provisions under this title shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.

27-50-5. Establishment of classes of business -- (a) A small employer carrier may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(2) The small employer carrier has acquired a class of business from another small employer carrier; or

(3) The small employer carrier provides coverage to one or more association groups that meet the definition of "group health benefit contract" to be offered to an association as specified in regulations promulgated under section 42-62-12.

(b) A small employer carrier may establish up to nine (9) separate classes of business under each subsections (a)(1) through (a)(3).

(c) The director may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (b) in the case of an acquisition of an additional class of business from another small employer carrier.

(d) The director may approve the establishment of additional classes of business upon application to the director and a finding by the director that the action would enhance the efficiency and fairness of the small employer marketplace.

27-50-6. Restrictions relating to premium rates -- (a) Premium rates for health benefit plans subject to this chapter are subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%);

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to the employers under the rating system for that class of business shall not vary from the index rate by more than twenty-five percent (25%) of the index rate;

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business;

(4) Adjustments in rates for claim experience, health status, and duration of coverage shall not be charged to individual employees or dependents. Any adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to section 27-50-11;

(6) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than thirty percent (30%);

(7) In the case of health benefit plans issued prior to July 1, 1992, a premium rate for a rating period may exceed the ranges set forth in subsections (a)(1) and (a)(2) for a period of three (3) years following July 1, 1992. In that case, the

~~percentage increase in the premium rate charged to a small employer in the class of business for a new rating period may not exceed the sum of the following:~~

~~(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; and~~

~~(ii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business; and~~

~~(8) (i) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefits;~~

~~(ii) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;~~

~~(9) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs;~~

~~(10) A small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size without prior approval of the director; and~~

~~(11) The director may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including:~~

~~(i) Assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and;~~

~~(ii) Prescribing the manner in which case characteristics may be used by small employer carriers.~~

~~(b) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage.~~

~~(c) The director may suspend for a specified period the application of subsection (a)(1) as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.~~

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

~~(1) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the employees of the small employer and their dependents;~~

~~(2) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and~~

factors, other than claim experience, that affect changes in premium rates;

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

(4) The provisions relating to any preexisting condition provision.

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

(2) Each small employer carrier shall file with the director annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. The certification shall be in such form and shall contain such information, as specified by the director. A copy of the certification shall be retained by the small employer carrier at its principal place of business;

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

27-50-7. Renewability of coverage -- (a) A health benefit plan subject to this chapter shall be renewable with respect to all eligible employees or dependents at the option of the employer except in any of the following cases:

(1) Nonpayment of the required premiums;

(2) Fraud or misrepresentation of the employer or, with respect to coverage of individual insureds, the insureds or their representatives;

(3) Noncompliance with the carrier's minimum participation requirements;

(4) Noncompliance with the carrier's employer contribution requirements;

(5) Repeated misuses of a provider network provision;

(6) The small employer carrier elects not to renew all of its health benefit plans issued to small employers in this state. In that case the carrier shall:

(i) Provide advance notice of this decision under this subsection to the insurance commissioner in each state in which it is licensed; and

(ii) Provide notice of the decision not to renew coverage to all affected small employers and to the insurance commissioner in each state in which an affected insured individual is known to reside at least one hundred eighty (180) days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the insurance commissioner under this subsection shall be provided at least three (3) working days prior to the notice to the affected small employers; or

(7) (i) The director finds that the continuation of the coverage would:

(A) Not be in the best interests of the policyholders or certificate holders; or

(B) Impair the carrier's ability to meet its contractual obligations.

(ii) In such instance the director shall assist affected small employers in finding replacement coverage.

(b) A small employer carrier that elects not to renew a health benefit plan under subsection (a)(6) shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of

notice to the director.

(c) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in that service area.

27-50-8. Availability of coverage -- (a) (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers at least two (2) health benefit plans. One health benefit plan offered by each small employer carrier shall be an economy health benefit plan and one plan shall be a standard health benefit plan;

(2) (i) A small employer carrier shall issue an economy health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the plan;

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to section 27-50-5, the small employer carrier shall maintain and issue to eligible small employers at least one economy health benefit plan and at least one standard health benefit plan in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business provided that:

(A) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(B) The criteria are not related to the health status or claim experience of the small employer;

(C) The criteria are applied consistently to all small employers applying for coverage in the class of business; and

(D) The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business;

(3) A small employer is eligible under subsection (a)(2) if it employed at least three (3) or more eligible employees within this state on at least fifty percent (50%) of its working days during the preceding calendar quarter;

(4) The provisions of this subsection shall be effective one hundred eighty (180) days after July 1, 1992; provided, that with respect to a reinsuring carrier, if the small employer health reinsurance program created pursuant to section 27-50-11 is not yet in operation on that date, the provisions of this subsection shall be effective on the date that the program begins operation.

(b) (1) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the economy health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this subsection may be used by a small employer carrier beginning thirty (30) days after it is filed unless the director disapproves its use;

(2) The director at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of an economy or standard health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

(c) Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

(i) A condition that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the six (6) months immediately preceding the effective date of coverage;

~~(ii) A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or~~

~~(iii) A pregnancy existing on the effective date of coverage;~~

~~(2) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services; provided, that the previous coverage was continuous to a date not less than thirty (30) days prior to the effective date of the new coverage. This subsection does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan;~~

~~(3) A health benefit plan may exclude coverage for late enrollees for the greater of eighteen (18) months or for an eighteen (18) month preexisting condition exclusion; provided, that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months from the date the individual enrolls for coverage under the health benefit plan;~~

~~(4) (i) Except as provided in subsection (e)(4)(iv), requirements used by a small employer carrier in determining whether to provide coverage to a small employer including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier;~~

~~(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group;~~

~~(iii) In applying minimum participation requirements with respect to a small employer, a small employer carrier may consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met;~~

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

~~(5) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage only to certain individuals in a small employer group or only to part of a group, except in the case of late enrollees as provided in subsection (e)(3);~~

~~(ii) A small employer carrier shall not modify an economy or standard health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.~~

~~(d) (1) A small employer carrier is not required to offer coverage or accept applications pursuant to subsection (a) in the case of the following:~~

~~(i) To a small employer, where the small employer is not physically located in the carrier's established geographic service area;~~

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

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

~~(2) A small employer carrier that cannot offer coverage pursuant to subsection (d)(1)(iii) may not offer coverage in the~~

applicable area to new cases of employer groups with more than fifty (50) eligible employees or to any small employer groups until the later of the one hundred eighty (180) days following each refusal or the date on which the carrier notifies the director that it has regained capacity to deliver services to small employer groups.

(c) A small employer carrier is not required to provide coverage to small employers pursuant to subsection (a) for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of subsection (a) would place the small employer carrier in a financially impaired condition.

27-50-9. Notice of intent to operate as a risk assuming carrier or a reinsuring carrier -- (a) Each carrier shall notify the director within thirty (30) days of July 1, 1992, of the carrier's intention to operate as a risk assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk assuming carrier shall make an application pursuant to section 27-50-10.

(b) The decision shall be binding for a five (5) year period, except that the initial decision shall be made within thirty (30) days of July 1, 1992, and shall be made for two (2) years. The director may permit a carrier to modify its decision at any time for good cause shown.

(c) The director shall establish an application process for small employer carriers seeking to change their status under this subsection.

27-50-10. Application to become a risk assuming carrier -- (a) A small employer carrier may apply to become a risk assuming carrier by filing an application with the director in a form and manner prescribed by the director.

(b) The director shall consider the following factors in evaluating an application filed under subsection (a):

(1) The carrier's financial condition;

(2) The carrier's history of rating and underwriting small employer groups;

(3) The carrier's commitment to market fairly to all small employers in the state or its established geographic service area, as applicable; and

(4) The carrier's experience with managing the risk of small employer groups.

(c) The director shall provide public notice of an application by a small employer carrier to be a risk assuming carrier and shall provide at least a sixty (60) day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the director, the carrier may request a hearing.

(d) The director may rescind the approval granted to a risk assuming carrier under this section if the director finds that:

(1) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with section 27-50-8 without the protection afforded by the program;

(2) The carrier has failed to market fairly to all small employers in the state or its established geographic service area, as applicable; or

(3) The carrier has failed to provide coverage to eligible small employers as required in section 27-50-8.

(e) A small employer carrier electing to be a risk assuming carrier shall not be subject to the provisions of section 27-50-11.

27-50-11. Small employer carrier reinsurance program -- (a) A reinsuring carrier shall be subject to the provision of this section.

(b) There is hereby created a nonprofit entity to be known as the small employer health reinsurance program.

~~(c) (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of subsection (c)(2), the board shall consist of eight (8) members appointed by the director, plus the director or the director's designated representative, who shall serve as an ex officio member of the board;~~

~~(2) In selecting the members of the board, the director shall choose representatives of reinsuring carriers;~~

~~(3) The initial board members shall be appointed as follows: one-third (1/3) of the members to serve a term of two (2) years; one-third (1/3) of the members to serve a term of four (4) years; and one-third (1/3) of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member's term shall continue until his or her successor is appointed;~~

~~(4) A vacancy in the board shall be filled by the director. A board member may be removed by the director for cause.~~

~~(d) Within sixty (60) days of July 1, 1992, each small employer carrier shall make a filing with the director containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.~~

~~(e) Within one hundred eighty (180) days after the appointment of the initial board, the board shall submit to the director a plan of operation and, thereafter, any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The director may, after notice and a hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable, and equitable administration of the program, and provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provision of this section. The plan of operation shall become effective upon approval in writing by the director.~~

~~(f) If the board fails to submit a suitable plan of operation within one hundred eighty (180) days after its appointment, the director shall, after notice and a hearing, promulgate and adopt a temporary plan of operation. The director shall amend or rescind any plan so adopted under this subsection at the time a plan of operation is submitted by the board and approved by the director.~~

~~(g) The plan of operation shall:~~

~~(1) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the director;~~

~~(2) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;~~

~~(3) Establish procedures for reinsuring risks in accordance with the provisions of this section;~~

~~(4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and~~

~~(5) Provide for any additional matters necessary for the implementation and administration of the program.~~

~~(h) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:~~

~~(1) Enter into contracts as necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the director, to enter into contracts with similar programs in other states for the joint performance of common functions or with persons or other organizations for the performance of administrative function;~~

~~(2) Sue or be sued, including taking any legal action necessary or proper to recover any assessments and penalties for,~~

~~on behalf of, or against the program or any reinsuring carriers;~~

~~(3) Take any legal action necessary to avoid the payment of improper claims against the program;~~

~~(4) Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this chapter;~~

~~(5) Establish rules, conditions, and procedures for reinsuring risks under the program;~~

~~(6) Establish actuarial functions as appropriate for the operation of the program;~~

~~(7) Assess reinsuring carriers in accordance with the provisions of subsection (l), and to make advance interim assessments as may be reasonable and necessary for organization and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year;~~

~~(8) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and~~

~~(9) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.~~

~~(i) A reinsuring carrier may reinsure with the program as provided for in this subsection:~~

~~(1) With respect to an economy health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in an economy or standard health benefit plan;~~

~~(2) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under a health benefit plan;~~

~~(3) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the coverage with the small employer. A newly eligible employee or dependent of a reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage;~~

~~(4) (i) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of five thousand dollars ($5,000) in a calendar year for benefits covered by the program. A reinsuring carrier's liability under this subsection shall not exceed a maximum limit of ten thousand dollars ($10,000) in any one calendar year with respect to any reinsured individual;~~

~~(ii) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "consumer price index for all urban consumers" of the department of labor and training, bureau of labor statistics, unless the board proposes and the director approves a lower adjustment factor;~~

~~(5) A small employer carrier may terminate reinsurance for one or more or the reinsured employees or dependents of a small employer on any plan anniversary.~~

~~(j) (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates, which shall be multiplied by the factors set forth in subsection (j)(2) to determine the premium rates for the~~

program. The base reinsurance premium rates shall be established by the board, subject to the approval of the director, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan;

(2) Premiums for the program shall be as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half (1 1/2) times the base reinsurance premium rate for the group established pursuant to this subsection; and

(ii) An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this subsection;

(3) The board periodically shall review the methodology established under subsection (j)(1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the director.

(k) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in section 27-50-6.

(l) (1) Prior to March 1 of each year, the board shall determine and report to the director the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses;

(2) Any net loss for the year shall be recouped by assessments of reinsuring carriers;

(i) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:

(A) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and

(B) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers;

(ii) The formula established pursuant to subsection (1)(2)(i) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than one hundred fifty percent (150%) of an amount which is based on the proportion of the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers;

(iii) The board may, with the approval of the director, change the assessment formula established pursuant to subsection (1)(2)(i) from time to time as appropriate. The board may provide for the share of the assessment based attributable to premiums from all health benefit plans and to premiums from newly issued health benefit plans to vary during a transition period;

(iv) Subject to the approval of the director, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. section 300 et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers;

(v) Premiums and benefits paid by a reinsuring carrier that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments;

~~(3) (i) Prior to March 1 of each year, the board shall determine and file with the director an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year;~~

~~(ii) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subsection (1)(3)(ii), the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the director within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include: an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of insurer retention under the program, and the costs of coverage for small employers. If the board fails to file report with the director within ninety (90) days following the end of the applicable calendar year, the director may evaluate the operations of the program and implement any amendments to the plan of operation the director deems necessary to reduce future losses and assessments;~~

~~(iii) For any calendar year, the amount specified in this subsection is five percent (5%) of total premiums earned in the previous year from health benefit plans delivered or issued for delivery, to small employers in this state by reinsuring carriers, except the amount may be increased by order of the director based on his or her determination in accordance with subsection (1)(3)(ii) that additional funds are needed.~~

~~**27-50-12. Standard and economy health benefit plans --** (a) No provision contained in this chapter shall prohibit the sale of health benefit plans which differ from the standard and economy health benefit plans provided for in this section. Only the standard and economy health benefit plans shall be exempted from the mandated benefits as provided for in section 27-50-14.~~

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

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

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

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

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

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

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

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

~~(viii) Psychiatric care and substance abuse care up to twenty (20) outpatient visits per year, inpatient psychiatric care and inpatient substance abuse care shall be included in the twenty (20) days provided by subsection (b)(1)(i). The lifetime substance abuse benefit shall be a maximum of forty-five (45) inpatient days; and~~

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

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

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

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

~~(ii) A two hundred dollar ($200) per day copayment will be charged for each day of inpatient hospitalization in any~~

acute care hospital or psychiatric care or substance abuse care treatment facility;

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

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

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

(i) Primary care gatekeepers;

(ii) Preadmission certification;

(iii) Mandatory second opinion prior to elective surgery;

(iv) Preauthorization for specified services;

(v) Concurrent utilization review and management;

(vi) Discharge planning for hospital care;

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

(viii) Less costly alternatives to inpatient care.

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

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

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

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

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

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

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

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

(viii) Psychiatric care and substance abuse care up to twenty (20) outpatient visits per year, inpatient psychiatric care and inpatient substance abuse care shall be included in the twenty (20) days provided by subsection (c)(1)(i). The lifetime substance abuse benefit shall be a maximum of forty-five (45) inpatient days; and

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

(2) The term "physician" shall include doctors of medicine, osteopathy, and optometry;

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

(i) A twenty percent (20%) copayment shall be charged for any covered service contained in subsections (e)(1)(iv), (e)(1)(vi), (e)(1)(vii), and (e)(1)(ix);

(ii) A three hundred dollar ($300) per day copayment will be charged for each day of inpatient hospitalization in any acute care hospital or psychiatric care or substance abuse care treatment facility;

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

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

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

(i) Primary care gatekeepers;

(ii) Preadmission certification;

(iii) Mandatory second opinion prior to elective surgery;

(iv) Preauthorization for specified services;

(v) Concurrent utilization review and management;

(vi) Discharge planning for hospital care;

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

(viii) Less costly alternatives to inpatient care.

27-50-13. Periodic market evaluation -- The director shall appoint a small employer health insurance study committee. The committee shall study and report at least every three (3) years to the director on the effectiveness of this chapter. The report shall analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance market-place. The report shall address whether carriers and producers are fairly actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the chapter. The report may contain recommendations for market conduct or other regulatory standards or action.

27-50-14. Waiver of certain state laws -- No law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization, or inclusion of a specific category of licensed health care practitioner, shall apply to an economy of standard health benefit plan issued pursuant to this chapter.

27-50-15. Administrative procedures -- The director shall issue regulations in accordance with chapter 35 of title 42 for the implementation and administration of the Small Employer Health Insurance Availability Act.

27-50-16. Standards to assure fair marketing -- (a) Each small employer carrier shall actively market health benefit plan coverage, including the economy and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase an economy health benefit plan and a standard health benefit plan.

(b) (1) Except as provided in subsection (b)(2), no small employer carrier or producer shall, directly or indirectly, engage in the following activities:

~~(i) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer; or~~

~~(ii) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry occupation, or geographic location of the small employer;~~

~~(2) The provisions of subsection (b)(1) shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.~~

~~(c) (1) Except as provided in subsection (c)(2), no small employer carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer;~~

~~(2) Subsection (c)(1) shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium; provided, that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.~~

~~(d) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of an economy or standard health benefit plan.~~

~~(e) No small employer carrier shall terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.~~

~~(f) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.~~

~~(g) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.~~

~~(h) The director may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.~~

~~(i) (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under chapter 29 of this title;~~

~~(2) If a small employer carrier enters into a contract, agreement, or other arrangement with a third party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third party administrator shall be subject to this section as if it were a small employer carrier.~~

~~**27-50-17. Severability --** If any provision of this chapter or the application of this chapter to any person or circumstances is for any reason held to be invalid, the remainder of the chapter and the application of its provisions to other persons or circumstances shall not be affected by this invalidity.~~

SECTION 10. Chapter 27-50 entitled "Small Employer Health Insurance Availability Act" is hereby amended by adding thereto the following sections:

27-50-1 Short title. -- This chapter shall be known and may be cited as the "Small Employer Health Insurance Availability Act".

27-50-2 Purpose. -- The purpose and intent of this chapter are to enhance the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to prevent

segmentation of the health insurance market based upon health risk, to spread health insurance risk more broadly, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to limit the use of preexisting condition exclusions, to provide for development of "economy", "standard" and "basic" health benefit plans to be offered to all small employers, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

This chapter is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

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

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

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

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

(E) "Basic health benefit plan" means the health benefit plan developed pursuant to the provisions of section 27-50-10.

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

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

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

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

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

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

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

(7) has a constitution and bylaws;

(8) meets such additional requirements as the director may prescribe by regulation.

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

(H) "Church plan" has the meaning given this term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(I) "Control" shall be defined in the same manner as in chapter 27-35.

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

(a) A group health plan;

(b) A health benefit plan;

(c) Part A or part B of Title XVIII of the Social Security Act (Medicare);

(d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 (the program for distribution of pediatric vaccines);

(e) Chapter 55 of title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents) (Civilian Health and Medical Program of the Uniformed Services) (CHAMPUS). For purposes of title 10, chapter 55, "uniformed services" means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service;

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

(g) A state health benefits risk pool;

(h) A health plan offered under chapter 89 of title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));

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

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

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

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

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

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

(N) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the term shall also include an employee who works on a full-time basis with a normal work week of anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this eligibility criterion is applied uniformly among all of the employer's employees and without regard to any health status-related factor. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis or who works less than seventeen and one-half (17.5) hours per week. Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation requirements pursuant to Section

27- 50-7(D)(9).

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

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

(Q) "Family composition" means:

(1) Enrollee;

(2) Enrollee, spouse and children;

(3) Enrollee and spouse; or

(4) Enrollee and children.

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

(S) "Governmental plan" has the meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

(T)(1) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in Subsection (Z), and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(2) For purposes of this chapter:

(a) Any plan, fund or program that would not be, but for PHSA section 2721(e), as added by Pub. L. No. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to Subparagraph (b), as an employee welfare benefit plan that is a group health plan;

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

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

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

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

(U) (1) "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, hospital or medical service corporation subscriber contract, or health maintenance organization subscriber contract. Health benefit plan includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-

incurred basis, except as otherwise specifically exempted in this definition.

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

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

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

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

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

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

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

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

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

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

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

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

(b) Hospital indemnity or other fixed indemnity insurance.

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

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; or

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

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

(a) The carrier files on or before March 1 of each year a certification with the director that contains the statement and information described in Subparagraph (b);

(b) The certification required in Subparagraph (a) shall contain the following:

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

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

(c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of the chapter, the carrier files with the director the information and statement required in subparagraph (b) at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state.

(V) "Health maintenance organization" or "HMO" means a health maintenance organization licensed under chapter 27-41.

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

(1) Health status;

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

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

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

(8) Disability.

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

(2) "Late enrollee" shall not mean an eligible employee or dependent

(a) Who meets each of the following:

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

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

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

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

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

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

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

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

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

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

(Z) "Medical care" means amounts paid for:

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

(2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and

(3) Insurance covering medical care referred to in Paragraphs (1) and (2).

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

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

(CC) "Plan sponsor" has the meaning given this term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

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

(2) "Preexisting condition" shall not mean a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the health benefit plan, provided that the prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.

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

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

(FF) "Producer" means any insurance producer licensed under chapter 27-2.3.

(GG) "Rating period" means the calendar period for which premium rates established by a small employer carrier are

assumed to be in effect.

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

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

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

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

(LL) "Small employer" means, except for its use in section 27-50-7, any person, firm, corporation, partnership, association, political subdivision or self-employed individual that is actively engaged in business, including but not limited to a business or a corporation organized under the Rhode Island Non-Profit Corporation Act or a similar act of another state that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week of thirty (30) or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered one (1) employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term small employer includes a self-employed individual.

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

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

27-50-4. Applicability and Scope. -- This chapter shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(A) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(B) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

(C) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code; or

(D) The health benefit plan is marketed to individual employees through an employer.

(E)(1) Except as provided in subsection (E) (2), for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state

by such affiliated carriers were issued by one (1) carrier.

(2) An affiliated carrier that is a health maintenance organization having a license under chapter 27-41 or a health maintenance organization as defined in chapter 42-62 may be considered to be a separate carrier for the purposes of this chapter.

(3) Unless otherwise authorized by the director, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The department of business regulation's statutory provisions under this title shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.

27-50-5. Restrictions Relating to Premium Rates. -- (A) Premium rates for health benefit plans subject to this act shall be subject to the following provisions:

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

(a) Age;

(b) Gender; and

(c) Family composition.

(2) Until October 1, 2002, a small employer carrier who as of June 1, 2000 varied rates by health status may vary the adjusted community rates for health status by ten percent (10%), provided that the resulting rates comply with the other requirements of this section, including subsection (5). After October 1, 2002, no small employer carrier may vary the adjusted community rate based on health status.

(3) The adjustment for age in Paragraph(1)(a) may not use age brackets smaller than five year increments and these shall begin with age thirty (30) and end with age sixty-five (65).

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

(5) For each health benefit plan offered by a carrier, the highest premium rate for each family composition type shall not exceed two (2) times the premium rate that could be charged to a small employer with the lowest premium rate for that family composition type, effective two (2) years after enactment of this chapter. During the first two (2) years after enactment of this chapter the highest premium rate for each family composition type shall not exceed four (4) times the premium rate that could be charged to a small employer with the lowest premium rate for that family composition.

(6) Upon renewal of a health benefit plan, the premium rate for each group shall not exceed the premium rate charged by that carrier to that group during the prior rating period by more than: (1) cost and utilization trends for that carrier; plus (2) the sum of any premium changes due to changes in the size, age, gender or family composition of the group; plus, (3) ten percent (10%); plus (4) the change in the actuarial value of the benefits due to changes in the health benefit plan for that group. This subsection shall expire on September 30, 2002.

(7) Premium rates for bona fide associations shall comply with the requirements of section 27-50-5.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27-50-6. Renewability of Coverage. -- (A) A health benefit plan subject to this chapter shall be renewable with respect

to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

(1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the carrier has not received timely premium payments;

(2) The plan sponsor or, with respect to coverage of individual insureds under the health benefit plan, the insured or the insured's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;

(3) Noncompliance with the carrier's minimum participation requirements;

(4) Noncompliance with the carrier's employer contribution requirements;

(5) The small employer carrier elects to discontinue offering all of its health benefit plans delivered or issued for delivery to small employers in this state if the carrier:

(a) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and

(b) Provides notice of the decision to:

(i) All affected small employers and enrollees and their dependents; and

(ii) The insurance commissioner in each state in which an affected insured individual is known to reside at least one hundred and eighty (180) days prior to the nonrenewal of any health benefit plans by the carrier, provided the notice to the commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected small employers and enrollees and their dependents;

(6) The director:

(a) Finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier's ability to meet its contractual obligations; and

(b) Assists affected small employers in finding replacement coverage;

(7) The director finds that the product form is obsolete and is being replaced with comparable coverage and the small employer carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the state's small employer market if the carrier:

(a) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;

(b) Provides notice of the decision not to renew coverage at least one hundred and eighty (180) days prior to the nonrenewal of any health benefit plans to:

(i) All affected small employers and enrollees and their dependents; and

(ii) The commissioner in each state in which an affected insured individual is known to reside, provided the notice sent to the commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected small employers and enrollees and their dependents;

(c) Offers to each small employer issued that particular type of health benefit plan (obsolete product form) the option to purchase all other health benefit plans currently being offered by the carrier to small employers in the state; and

(d) In exercising this option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage pursuant to Subparagraph (c) acts uniformly without regard to the claims experience of those small employers or any health status-related factor relating to any enrollee or dependent of an enrollee or enrollees

and their dependents covered or new enrollees and their dependents who may become eligible for coverage; or

(8) In the case of health benefit plans that are made available in the small group market through a network plan, there is no longer an employee of the small employer living, working or residing within the carrier's established geographic service area and the carrier would deny enrollment in the plan pursuant to section 27-50-7(E)(1)(b); or,

(9) In the case of a health benefit plan that is made available in the small employer market only through one or more bona fide associations, the membership of an employer in the bona fide association, on the basis of which the coverage is provided, ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

(B)(1) A small employer carrier that elects not to renew health benefit plan coverage pursuant to subsection (A)(2) because of the small employer's fraud or intentional misrepresentation of material fact under the terms of coverage may choose not to issue a health benefit plan to that small employer for one (1) year after the date of nonrenewal.

(2) This subsection shall not be construed to affect the requirements of section 27-50-7 as to the obligations of other small employer carriers to issue any health benefit plan to the small employer.

(C)(1) A small employer carrier that elects to discontinue offering health benefit plans under subsection (A)(5) shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

(2) In the case of a small employer carrier that ceases offering new coverage in this state pursuant to subsection (A)(5), the small employer carrier, as determined by the director, may renew its existing business in the small employer market in the state or may be required to nonrenew all of its existing business in the small employer market in the state.

(D) A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (A) or (B) in the case of the following:

(i) to an eligible person who no longer resides, lives or works in the service area, or in an area for which the carrier is authorized to do business, but only if coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

(ii) to a small employer that no longer has any enrollee in connection with such plan who lives, resides or works in the service area of the carrier, or the area for which the carrier is authorized to do business.

27-50-7. Availability of Coverage. -- (A) Until October 1, 2002, for purposes of this section, "small employer" includes any person, firm, corporation, partnership, association or political subdivision that is actively engaged in business that on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed a combination of no more than fifty (50) and no less than two (2) eligible employees and part-time employees, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. After October 1, 2002, for the purposes of this section, "small employer" shall have the meaning used in subsection (LL) of section 27-50-3.

(B)(1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state including at least three (3) health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan, one plan shall be a standard health benefit plan, and one plan shall be an economy health benefit plan. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to any small employer not currently receiving a health benefit plan from such small employer carrier.

(2) Subject to subsection (1), a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter. However, no carrier shall be required to issue a health benefit plan to any self-employed individual who is covered by, or is eligible for coverage under, a health benefit

plan offered by an employer.

(3) Notwithstanding any other provision in this section, between October 1, 2000 and September 30, 2002, a carrier may choose to limit the time during which it will accept new groups for coverage to a period of not less than ninety consecutive days during each consecutive twelve month period.

(C) (1) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the director disapproves its use.

(2) The director may at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a health benefit plan on the grounds that the plan does not meet the requirements of this act.

(D) Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than six (6) months following the enrollment date of the individual's coverage due to a preexisting condition, or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a preexisting condition more restrictively than as defined in section 27-50-3.

(2)(a) Except as provided in subsection (3), a small employer carrier shall reduce the period of any preexisting condition exclusion without regard to the specific benefits covered during the period of creditable coverage, provided that the last period of creditable coverage ended on a date not more than ninety (90) days prior to the enrollment date of new coverage.

(b) The aggregate period of creditable coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the employer or the carrier, or for the normal application and enrollment process following employment or other triggering event for eligibility.

(c) A carrier that does not use preexisting condition limitations in any of its health benefit plans may impose an affiliation period that:

(i) Does not exceed sixty (60) days for new entrants and not to exceed ninety (90) days for late enrollees;

(ii) During which the carrier charges no premiums and the coverage issued is not effective; and

(iii) Is applied uniformly, without regard to any health status-related factor.

(d) This section does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan, provided that any carrier-imposed waiting period be no longer than sixty (60) days.

(3)(a) Instead of as provided in subsection (2)(a), a small employer carrier may elect to reduce the period of any preexisting condition exclusion based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations.

(b) A small employer electing to reduce the period of any preexisting condition exclusion using the alternative method described in subsection (3)(a) shall:

(i) Make the election on a uniform basis for all enrollees; and

(ii) Count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(c) A small employer carrier electing to reduce the period of any preexisting condition exclusion using the alternative method described under subsection (3)(a) shall:

(i) Prominently state that the election has been made in any disclosure statements concerning coverage under the health benefit plan to each enrollee at the time of enrollment under the plan and to each small employer at the time of the offer or sale of the coverage; and

(ii) Include in the disclosure statements the effect of the election.

(4)(a) A health benefit plan shall accept late enrollees, but may exclude coverage for late enrollees for preexisting conditions for a period not to exceed twelve (12) months.

(b) A small employer carrier shall reduce the period of any preexisting condition exclusion pursuant to Paragraph (2) or Paragraph (3).

(5) A small employer carrier shall not impose a preexisting condition exclusion:

(a) Relating to pregnancy as a preexisting condition; or

(b) With regard to a child who is covered under any creditable coverage within thirty (30) days of birth, adoption or placement for adoption, provided that the child does not experience a significant break in coverage, and provided that the child was adopted or placed for adoption before attaining eighteen (18) years of age.

(6) A small employer carrier shall not impose a preexisting condition exclusion in the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage, and the medical advice, diagnosis, care or treatment was a covered benefit under the plan, provided that the creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.

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

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

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

(iii) The employee's or dependent's coverage described under Item (i):

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

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

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

(b) If an employee requests enrollment pursuant to Item (iv), the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

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

(i) The individual is a participant under the health benefit plan or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan, but for a failure to enroll during a previous enrollment period; and

(ii) A person becomes a dependent of the individual through marriage, birth or adoption or placement for adoption.

(b) The special enrollment period for individuals that meet the provisions of subsection (8)(a) shall be a period of not less than thirty (30) days and begins on the later of:

(i) The date dependent coverage is made available; or

(ii) The date of the marriage, birth or adoption or placement for adoption described in Subparagraph (a)(ii).

(c) If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period described under Subparagraph (b), the coverage of the dependent shall be effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent's birth, as of the date of birth; and

(iii) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(9)(a) Except as provided in this subsection, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier.

(b) For health benefit plans issued or renewed on or after October 1, 2000, a small employer carrier shall not require a minimum participation level greater than:

(i) One hundred percent (100%) of eligible employees working for groups of ten (10) or less employees; and

(ii) Seventy-five percent (75%) of eligible employees working for groups with more than ten (10) employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met.

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

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

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

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

(E)(1) Subject to subsection (E)(3), a small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (B) in the case of the following:

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

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

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

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

(3) A small employer carrier shall apply the provisions of this subsection uniformly to all small employers without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

(F)(1) A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection (B) if:

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

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

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

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

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

(G)(1) A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection (B) if the small employer carrier elects not to offer new coverage to small employers in this state.

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

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

carrier ceased offering new coverage in this state.

27-50-8. Certification of Creditable Coverage. -- (A) Small employer carriers shall provide written certification of creditable coverage to individuals in accordance with subsection (B).

(B) The certification of creditable coverage shall be provided:

(1) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(2) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(3) At the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in subsection (B) (1) or (B) (2), whichever is later.

(C) Small employer carriers may provide the certification of creditable coverage required under subsection (B)(1) at a time consistent with notices required under any applicable COBRA continuation provision.

(D) The certificate of creditable coverage required to be provided pursuant to Subsection (A) shall contain:

(1) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

(2) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

(E) To the extent medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under Subsection (A) if the carrier offering the coverage provides for certification in accordance with Subsection (B).

(F)(1) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage pursuant to Section 27-50-7(C)(3) of this act and the individual provides a certificate of coverage that was provided to the individual pursuant to subsection (B), on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity's health benefit plan.

(2) The entity providing the information pursuant to Paragraph (1) may charge the requesting group health plan the reasonable cost of disclosing the information.

27-50-9. Periodic market evaluation. -- Within three (3) months after March 31, 2002, September 30, 2003, and every thirty-six (36) months thereafter, the director shall obtain an independent actuarial study and report. The director shall assess the health plans a fee to commission said report. The report shall analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance market-place. The report shall address whether carriers and producers are fairly actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the chapter. The report may contain recommendations for market conduct or other regulatory standards or action.

27-50-10. Basic, standard and economy health benefit plans. -- (A) No provision contained in this chapter shall prohibit the sale of health benefit plans which differ from the basic, standard and economy health benefit plans provided for in this section. Only the standard and economy health benefit plans shall be exempted from the mandated benefits as provided for in section 27-50-13.

(B)(1) The standard health benefit plan shall include:

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

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

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

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

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

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

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

(viii) Psychiatric care and substance abuse care up to twenty (20) outpatient visits per year, inpatient psychiatric care and inpatient substance abuse care shall be included in the twenty (20) days provided by subsection (B)(1)(i). The lifetime substance abuse benefit shall be a maximum of forty-five (45) inpatient days; and

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

(2) The term "physician" shall include doctors of medicine, osteopathy, and optometry;

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

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

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

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

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

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

(i) Primary care gatekeepers;

(ii) Preadmission certification;

(iii) Mandatory second opinion prior to elective surgery;

(iv) Preauthorization for specified services;

(v) Concurrent utilization review and management;

(vi) Discharge planning for hospital care;

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

(viii) Less costly alternatives to inpatient care.

(C)(1) The economy health benefit plan shall include:

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

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

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

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

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

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

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

(viii) Psychiatric care and substance abuse care up to twenty (20) outpatient visits per year, inpatient psychiatric care and inpatient substance abuse care shall be included in the twenty (20) days provided by subsection (C)(1)(i). The lifetime substance abuse benefit shall be a maximum of forty-five (45) inpatient days; and

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

(2) The term "physician" shall include doctors of medicine, osteopathy, and optometry;

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

(i) A twenty percent (20%) copayment shall be charged for any covered service contained in subsections (C)(1)(iv), (C)(1)(vi), (C)(1)(vii), and (C)(1)(ix);

(ii) A three hundred dollar ($300) per day copayment will be charged for each day of inpatient hospitalization in any acute care hospital or psychiatric care or substance abuse care treatment facility;

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

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

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

(i) Primary care gatekeepers;

(ii) Preadmission certification;

(iii) Mandatory second opinion prior to elective surgery;

(iv) Preauthorization for specified services;

(v) Concurrent utilization review and management;

(vi) Discharge planning for hospital care;

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

(viii) Less costly alternatives to inpatient care.

(D) The basic health benefit plan shall be developed by regulation by the director in consultation with the department of human services, including, but not limited to, benefit levels, cost-sharing levels, exclusions and limitations. The plan may include cost containment features such as those specified in subsections (B)(4) and (C)(4). The plan shall be made available as required by regulation.

27-50-11. Administrative procedures. - The director shall issue regulations in accordance with chapter 42-35 for the implementation and administration of the Small Employer Health Insurance Availability Act.

27-50-12. Standards to assure fair marketing. -- (A) Each small employer carrier shall actively market and offer all health benefit plans sold by the carrier to eligible small employers in the state.

(B)(1) Except as provided in subsection (B)(2), no small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of any health status-related factor, age, gender, industry, occupation or geographic location of the small employer;

(b) Encouraging or directing small employers to seek coverage from another carrier because of any health status-related factor, age, gender, industry, occupation or geographic location of the small employer.

(2) The provisions of subsection (B)(1) shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(C)(1) Except as provided in subsection (C)(2), no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of any initial or renewal, industry, occupation or geographic location of the small employer.

(2) Subsection (C)(1) shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of any health status-related factor, industry, occupation or geographic area of the small employer.

(D) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of any health benefit plan subject to section 27-50-10.

(E) No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to health status-related factor, occupation or geographic location of the small employers placed by the producer with the small employer carrier.

(F) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee or dependent from health coverage or benefits provided in connection with the employee's employment.

(G) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(H) The director may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(I)(1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under chapter 6-13.

(2) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

27-50-13. Waiver of certain state laws. -- No law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, shall apply to a basic, economy or standard health benefit plan delivered or issued for delivery to small employers in this state pursuant to this chapter.

27-50-14. Severability. If any provision of this chapter or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the chapter and the application of its provisions to other persons or circumstances shall not be affected thereby.

27-50-15. Restoration of terminated coverage. -- The director may promulgate regulations to require small employer carriers, as a condition of transacting business with small employers in this state after the effective date of this chapter, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier on or after July 1, 2000. The director may prescribe such terms for the reissue of coverage as the director finds are reasonable and necessary to provide continuity of coverage to small employers.

27-50-16. Risk adjustment mechanism. -- The director may establish a payment mechanism to adjust for the amount of risk covered by each small employer carrier. The director may appoint an advisory committee composed of individuals that have risk adjustment and actuarial expertise to help establish the risk adjusters.

PART III HEALTH INSURERS' ACCOUNTABILITY

SECTION 11. Title 27 of the General Laws entitled "Insurance" is hereby amended by adding thereto the following chapter:

CHAPTER 4.7
RISK-BASED CAPITAL (RBC) FOR HEALTH ORGANIZATIONS ACT

27-4.7-1. Short title. -- This chapter shall be known and may be cited as the Rhode Island Risk-Based Capital (RBC) for Health Organizations Act.

27-4.7-2. Definitions. -- As used in this chapter, the following terms shall have the following meanings:

(1) "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with section 27-4.7-3;

(2) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required;

(3) "Commissioner" means the Director of the Department of Business Regulation;

(4) "Domestic health organization" means a health organization domiciled in this state;

(5) "Foreign health organization" means a health organization that is licensed or otherwise authorized to do business in this state pursuant to title 27 but is not domiciled in this state;

(6) "NAIC" means the National Association of Insurance Commissioners;

(7) "Health organization" means a health maintenance organization, limited health service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization or any other entity providing a plan of health insurance, health benefits, or health services subject to title 27. This definition does not include an organization that is licensed as either a life and health insurer or a property and casualty insurer pursuant to chapter 27-1 or chapter 27-2 and that is otherwise subject to either the life or property and casualty RBC requirements;

(8) "RBC" means risk-based capital;

(9) "RBC instructions" means the RBC report, including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;

(10) "RBC level" means a health organization's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(i) "Company action level RBC" means, with respect to any health organization, the product of two (2.0) and its authorized control level RBC;

(ii) "Regulatory action level RBC" means the product of one and one-half (1.5) and its authorized control level (RBC);

(iii) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(iv) "Mandatory control level RBC" means the product of seven tenths (.70) and the authorized control level RBC.

(11) "RBC plan" means a comprehensive financial plan containing the elements specified in section 27-4.7-4(b). If the commissioner rejects the RBC plan, and it is revised by the health organization, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan";

(12) "RBC report" means the report required in section 27-4.7-3;

(13) "Total adjusted capital" means the sum of:

(i) health organization's statutory capital and surplus (i.e. net worth) as determined in accordance with the statutory accounting applicable to the annual and quarterly financial statements required to be filed by health organizations pursuant to applicable sections of title 27; and

(ii) Such other items, if any, as the RBC instructions may provide.

27-4.7-3. RBC reports. -- (a) A domestic health organization shall, on or prior to each March 1 (the "filing date"), prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a domestic health organization shall file its RBC report:

(1) With the NAIC in accordance with the RBC instructions; and

(2) With the insurance commissioner in any state in which the health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its RBC report not later than the later of:

(i) Fifteen (15) days from the receipt of notice to file its RBC report with that state; or

(ii) The filing date.

(b) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC instructions:

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(c) An excess of capital (i.e. net worth) over the amount produced by the risk-based capital requirements contained in this chapter and the formulas, schedules and instructions referenced in this chapter is desirable in the business of health insurance. Accordingly, health organizations should seek to maintain capital above the RBC levels required by this chapter. Additional capital is used and useful in the insurance business and helps to secure a health organization against various risks inherent in, or affecting, the business of insurance and not accounted for, or only partially measured by, the risk-based capital requirements contained in this chapter.

(d) If a domestic health organization files an RBC report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

27-4.7-4. Company action level event. -- (a) "Company Action Level Event" means any of the following events:

(1) The filing of an RBC report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(2) Notification by the commissioner to the health organization of an adjusted RBC report that indicates an event in paragraph (1) of this subsection, provided the health organization does not challenge the adjusted RBC report under section 27-4.7-8; or

(3) If, pursuant to section 27-4.7-8, a health organization challenges an adjusted RBC report that indicates the event in paragraph (1) of this subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(b) In the event of a company action level event, the health organization shall prepare and submit to the commissioner an RBC plan that shall:

(1) Identify the conditions that contribute to the company action level event;

(2) Contain proposals of corrective actions that the health organization intends to take and that would be expected to result in the elimination of the company action level event;

(3) Provide projections of the health organization's financial results in the current year and at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(4) Identify the key assumptions impacting the health organization's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the health organization's business, including but not limited to

its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(c) The RBC plan shall be submitted:

(1) Within forty-five (45) days of the company action level event; or

(2) If the health organization challenges an adjusted RBC report pursuant to section 27-4.7-8 within forty-five (45) days after notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(d) Within sixty (60) days after the submission by a health organization of an RBC plan to the commissioner, the commissioner shall notify the health organization whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, in the notification to the health organization shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory in the judgment of the commissioner. Upon notification from the commissioner, the health organization shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(1) Within forty-five (45) days after the notification from the commissioner; or

(2) If the health organization challenges the notification from the commissioner under section 27-4.7-8, within forty-five (45) days after a notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(e) In the event of a notification by the commissioner to a health organization that the health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, at the commissioner's discretion, subject to the health organization's right to a hearing under section 27-4.7-8, specify in the notification that the notification constitutes a regulatory action level event.

(f) Every domestic health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the health organization is authorized to do business if:

(1) The state has an RBC provision substantially similar to section 27-4.7-9(a); and

(2) The insurance commissioner of that state has notified the health organization of its request for the filing in writing, in which case the health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(a) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(b) The date on which the RBC plan or revised RBC plan is filed under subsections (c) and (d) of this section.

27-4.7-5. Regulatory action level event. -- (a) "Regulatory action level event" means, with respect to a health organization, any of the following events:

(1) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(2) Notification by the commissioner to a health organization of an adjusted RBC report that indicates the event in paragraph (1) of this subsection, provided the health organization does not challenge the adjusted RBC report under section 27-4.7-8;

(3) If, pursuant to section 27-4.7-8, the health organization challenges an adjusted RBC report that indicates the event in

paragraph (1) of this subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(4) The failure of the health organization to file an RBC report by the filing date, unless the health organization has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within ten (10) days after the filing date;

(5) The failure of the health organization to submit an RBC plan to the commissioner within the time period set forth in section 27-4.7-4(c);

(6) Notification by the commissioner to the health organization that:

(a) The RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the commissioner, unsatisfactory; and

(b) Notification constitutes a regulatory action level event with respect to the health organization, provided the health organization has not challenged the determination under section 27-4.7-8.

(7) If, pursuant to section 27-4.7-8, the health organization challenges a determination by the commissioner under paragraph (6) of this subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge;

(8) Notification by the commissioner to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the health organization has not challenged the determination under section 27-4.7-8; or

(9) If, pursuant to section 27-4.7-8, the health organization challenges a determination by the commissioner under paragraph (8) of this subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge.

(b) In the event of a regulatory action level event the commissioner shall:

(1) Require the health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) Perform such examination or analysis as the commissioner deems necessary of the assets, liabilities and operations of the health organization including a review of its RBC plan or revised RBC plan; and

(3) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the commissioner shall determine are required (a "corrective order").

(c) In determining corrective actions, the commissioner may take into account factors the commissioner deems relevant with respect to the health organization based upon the commissioner's examination or analysis of the assets, liabilities and operations of the health organization, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(1) Within forty-five (45) days after the occurrence of the regulatory action level event;

(2) If the health organization challenges an adjusted RBC report pursuant to section 27-4.7-8 and the challenge is not frivolous in the judgment of the commissioner within forty-five (45) days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge; or

(3) If the health organization challenges a revised RBC plan pursuant to section 27-4.7-8, and the challenge is not frivolous in the judgment of the commissioner, within forty-five (45) days after the notification to the health

organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(d) The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations (including contractual relationships) of the health organization and formulate the corrective order with respect to the health organization. The fees, costs and expenses relating to consultants shall be borne by the affected health organization or such other party as directed by the commissioner.

27-4.7-6. Authorized control level event. -- (a) "Authorized control level event" means any of the following events:

(1) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(2) The notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in paragraph (1), provided the health organization does not challenge the adjusted RBC report under section 27-4.7-8;

(3) If, pursuant to section 27-4.7-8, the health organization challenges an adjusted RBC report that indicates the event in paragraph (1), notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(4) The failure of the health organization to respond, in a manner satisfactory to the commissioner, to a corrective order (provided the health organization has not challenged the corrective order under section 27-4.7-8); or

(5) If the health organization has challenged a corrective order under section 27-4.7-8 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(b) In the event of an authorized control level event with respect to a health organization, the commissioner shall:

(1) Take such actions as are required under section 27-4.7-5 regarding a health organization with respect to which a regulatory action level event has occurred; or

(2) If the commissioner deems it to be in the best interests of the policyholders and creditors of the health organization and of the public, take such actions as are necessary to cause the health organization to be placed under regulatory control pursuant to chapters 27-14.1, 27-14.2 and 27-14.3. In the event the commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the commissioner to take action under chapters 27-14.1, 27-14.2 and 27-14.3, and the commissioner shall have the rights, powers and duties with respect to the health organization as are set forth in chapters 27-14.1, 27-14.2 and 27-14.3. In the event the commissioner takes actions under this paragraph pursuant to an adjusted RBC report, the health organization shall be entitled to such protections as are afforded to health organizations under the provisions of chapter 35 of title 42 pertaining to summary proceedings.

27-4.7-7. Mandatory control level event. -- (a) "Mandatory control level event" means any of the following events:

(1) The filing of an RBC report which indicates that the health organization's total adjusted capital is less than its mandatory control level RBC;

(2) Notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in paragraph (1) of this subsection, provided the health organization does not challenge the adjusted RBC report under section 27-4.7-8; or

(3) If, pursuant to section 27-4.7-8, the health organization challenges an adjusted RBC report that indicates the event in paragraph (1) of this subsection, notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(b) In the event of a mandatory control level event, the commissioner shall take such actions as are necessary to place the health organization under regulatory control pursuant to chapters 27-14.1, 27-14.2 and 27-14.3. In that event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under chapters 27-14.1, 27-14.2 and 27-14.3, and the commissioner shall have the rights, powers and duties with respect to the health organization as are set forth in chapters 27-14.1, 27-14.2 and 27-14.3. If the commissioner takes actions pursuant to an adjusted RBC report, the health organization shall be entitled to the protections of chapter 35 of title 42 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety (90) days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.

27-4.7-8. Hearings. -- Upon the occurrence of any of the following events the health organization shall have the right to a confidential department hearing, on the record, at which the health organization may challenge any determination or action by the commissioner. The health organization shall notify the commissioner of its request for a hearing within five (5) days after the notification by the commissioner under subsections (a), (b), (c) or (d) of this section. Upon receipt of the health organization's request for a hearing, the commissioner shall set a date for the hearing, which shall be no less than ten (10) days nor more than thirty (30) days after the date of the health organization's request. The events include:

(a) Notification to a health organization by the commissioner of an adjusted RBC report;

(b) Notification to a health organization by the commissioner that:

(1) The health organization's RBC plan or revised RBC plan is unsatisfactory; and

(2) Notification constitutes a regulatory action level event with respect to the health organization;

(c) Notification to a health organization by the commissioner that the health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event with respect to the health organization in accordance with its RBC plan or revised RBC plan; or

(d) Notification to a health organization by the commissioner of a corrective order with respect to the health organization.

27-4.7-9. Confidentiality -- Prohibition on announcements -- Prohibition on use in ratemaking. -- (a) All RBC reports (to the extent the information is not required to be set forth in a publicly available annual statement schedule) and RBC plans (including the results or report of any examination or analysis of a health organization performed pursuant to this chapter and any corrective order issued by the commissioner pursuant to examination or analysis) with respect to a domestic health organization or foreign health organization that are filed with the commissioner constitute information that might be damaging to the health organization if made available to its competitors, and therefore shall be kept confidential by the commissioner. This information shall not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to this chapter or any other provision of the insurance laws of this state.

(b) It is the judgment of the legislature that the comparison of a health organization's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for corrective action with respect to the health organization, and is not intended as a means to rank health organizations generally. Therefore, except as otherwise required under the provisions of this chapter, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any health organization, or of any component derived in the calculation, by any health organization, agent, broker or other person engaged in any manner in the insurance business, would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding a health organization's total adjusted capital to its RBC levels (or any of them) or an inappropriate

comparison of any other amount to the health organization's RBC levels is published in any written publication and the health organization is able to demonstrate to the commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the health organization may publish an announcement in a written publication, if the sole purpose of the announcement is to rebut the materially false statement.

27-4.7-10. Supplemental provisions -- Rules -- Exemption. -- (a) The provisions of this chapter are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the commissioner under such laws, including, but not limited to, chapters 41, 19, 20, 20.1, 20.2, 20.3, 14.1, 14.2 and 14.3 of this title. The provisions of this chapter shall supercede any provisions of title 27 in conflict with this chapter.

(b) The commissioner may adopt reasonable rules necessary for the implementation of this chapter.

(c) The commissioner may exempt from the application of this chapter or modify the requirements of this chapter for:

(1) a domestic health organization that:

(A) Writes direct business only in this state;

(B) Assumes no reinsurance in excess of five percent (5%) of direct premium written; and

(C) Writes direct annual premiums for comprehensive medical business of two million dollars ($2,000,000) or less; or

(D) Is a limited health service organization that covers less than two thousand (2,000) lives; or

(2) A domestic health organization that provides a plan of health insurance, health benefits, or health services to members, eighty-five percent (85%) or greater of which are participants in the RIte Care program administered by the State of Rhode Island, if the health organization has contracts with insurers, hospital or medical service corporations, governments or other organizations that are sufficient to reasonably assure the performance of its obligations; provided, however, that in no event shall the net worth or total adjusted capital requirement be less than one hundred thousand dollars ($100,000).

27-4.7-11. Foreign health organizations. -- (1) A foreign health organization shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended the later of:

(A) The date an RBC report would be required to be filed by a domestic health organization under this chapter;

(B) Fifteen (15) days after the request is received by the foreign health organization.

(2) A foreign health organization shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(b) In the event of a company action level event, regulatory action level event or authorized control level event with respect to a foreign health organization as determined under the RBC statute applicable in the state of domicile of the health organization (or, if no RBC statute is in force in that state, under the provisions of this chapter), if the insurance commissioner of the state of domicile of the foreign health organization fails to require the foreign health organization to file an RBC plan in the manner specified under that state's RBC statute (or, if no RBC statute is in force in that state, under section 27-4.7-4), the commissioner may require the foreign health organization to file an RBC plan with the commissioner. In such event, the failure of the foreign health organization to file an RBC plan with the commissioner shall be grounds to order the health organization to cease and desist from writing new insurance business in this state.

(c) In the event of a mandatory control level event with respect to a foreign health organization, if no domiciliary receiver has been appointed with respect to the foreign health organization under the rehabilitation and liquidation statue applicable in the state of domicile of the foreign health organization, the commissioner may make application to the superior court of the county of Providence permitted under chapter 27-14.3 with respect to the liquidation of property of foreign health organizations found in this state, and the occurrence of the mandatory control level event shall be

considered adequate grounds for the application.

27-4.7-12. Immunity. -- There shall be no liability on the part of, and no cause of action shall arise against, the commissioner or the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under this chapter.

27-4.7-13. Severability clause. -- If any provision of this chapter, or its application to any person or circumstance, is held invalid, that determination shall not affect the provisions or applications of this chapter that can be given effect without the invalid provision or application, and to that end the provisions of this chapter are severable.

27-4.7-14. Notices. -- All notices by the commissioner to a health organization that may result in regulatory action under this chapter shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the health organization's receipt of notice.

27-4.7-15. Phase-In provision. -- For RBC reports required to be filed by health organizations with respect to the years 2000 and 2001, the following requirements shall apply in lieu of the provisions of sections 27-4.7-4, 27-4.7-5, 27-4.7-6 and 27-4.7-7 of this chapter. However, in no event shall any of the following requirements preclude any action or limit any powers or duties otherwise available to the insurance commissioner under any other state laws or regulation.

(a) In the event of a company action level event with respect to a domestic health organization, the commissioner shall take no regulatory action under this chapter.

(b) In the event of a regulatory action level event under section 27-4.7-5(a)(1), (2) or (3) with respect to a domestic health organization, the commissioner shall take the actions required under section 27-4.7-4 with respect to the health organization.

(c) In the event of a regulatory action level event under section 27-4.7-5(a)(4), (5), (6), (7), (8) or (9) or an authorized control level event, the commissioner shall take the actions required under section 27-4.7-5 with respect to the health organization.

(d) In the event of a mandatory control level event with respect to a health organization, the commissioner shall take the actions required under section 27-4.7-6 with respect to the health organization.

(e) In the event the health organization's total adjusted capital at December 31, 2000 is less than the product of twenty-five one hundredths (.25) and its authorized control level RBC, the commissioner shall take the actions required under section 27-4.7-7 with respect to the health organization.

(f) In the event the health organization's total adjusted capital at December 31, 2001 is less than the product of one-half (.5) and its authorized control level RBC, the commission shall take the actions required under section 27-4.7-7 with respect to the health organization.

27-4.7-16. Prior notification of discontinuance of health insurance coverage. -- (a) At any time that a health organization elects to discontinue providing all health benefit plans to either individual or group policyholders in this state, the health organization shall: provide written notice of this decision to the director of health and the director of the department of business regulation and to all affected health benefit plan group and individual policyholders at least one hundred eighty (180) days prior to the planned date of discontinuation of all health benefit plans by the health organization. However, notice to the director of health and the director of the department of business regulation shall be provided at least five (5) working days prior to the notice to affected enrollees.

(b) Any health organization in violation of this notification requirement shall be subject to an administrative penalty in an amount not less than five hundred dollars ($500) nor more than fifty thousand dollars ($50,000).

SECTION 12. Section 27-12-1 of the General Laws in Chapter 27-12 entitled "Annual Reports of Insurance Companies" is hereby amended to read as follows:

27-12-1. Time of filing -- Contents of report. -- (a) Every insurance company of whatever name or kind, doing business in this state, shall annually on the first day of January, or within two (2) months thereafter, file with the insurance commissioner an annual national association of insurance commissioners statement convention blank, prepared in accordance with the national association of insurance commissioners annual statement instructions and accounting practices and procedures manuals, examiners' handbook, securities valuation manual and such other manuals published by the national association of insurance commissioners as may be amended from time to time, signed and sworn to by its president and secretary, of its exact condition specifying that the company is a fire, marine, fire and marine, life, health, accident, or other insurance company, as the case may be; stating the amount of its capital and the manner of its investment; designating the amount invested respectively in mortgages, in what companies, particularizing each item of investment; the amount of marine risks not terminated, and the premium paid thereon; the amount of fire risks not terminated, and the premium paid thereon; the amount of liabilities, specifying therein the amount of outstanding claims, adjusted or unadjusted, due or not due; and in case the company is incorporated on the mutual principle, the statement shall set forth, in addition to the foregoing, the amount of risks insured by the company, the amount of premium thereon, what portion of it has been paid in cash, what security has been taken for the remainder, and what is the largest sum insured in any one risk; and, except in the case of a company writing less than one million dollars ($1,000,000) of total direct plus assumed written premiums during a calendar year or which has fewer than one thousand (1,000) policyholders or certificate holders at the end of a calendar year, a statement of actuarial opinion relating to loss and loss adjustment expense reserves; and, except in the case of a company having direct premiums written of less than one million dollars ($1,000,000) in any calendar year and fewer than one thousand (1,000) policyholders or certificate holders at the end of a calendar year, an audited financial report prepared by an independent certified public accountant; and the statement herein required to be made, so far as applicable, shall be made of each class in companies authorized to take risks in classes, and in all cases the returns may be varied by the commissioner to obtain more definite information of the company; and shall pay a filing fee of one hundred dollars ($100).

(b) Companies may be required to file quarterly statements upon request by the insurance commissioner, in accordance with the national association of insurance commissioners' guidelines and procedures, due on or before forty-five (45) days after the quarter ending. Annual and quarterly statements shall be available for inspection by the public.

(c) The commissioner may assess a late fee of one hundred dollars ($100) per day for each day the insurer is late in filing its annual or quarterly statement, except that the insurer may request and receive a reasonable extension of the filing date without penalty.

(d) Provisions of this chapter shall apply to corporations organized under chapters 19, 20, 20.1, 20.2 and 20.3 and 41 of title 27.

(e) With respect to individual and group health benefit contracts, including managed care contracts, written by an insurance company or health organization subject to the requirements of this chapter, when the expected claim payments or incurred costs, claims adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, the insurer or health organization shall recognize a premium deficiency reserve by recording an additional liability for the deficiency, with a corresponding charge to operations. The reserve shall be calculated in accordance with regulations promulgated pursuant to this chapter.

(f) In addition to the powers which the commissioner has under other sections of this title relating to the financial statements of health organizations, the commissioner shall also have the power to require any health organizations subject to this title to file the annual audited financial statements of its controlling affiliate or person whether or not the controlling affiliate or person is licensed or authorized pursuant to this title. Additionally, if the controlling affiliate or person is an insurer or health organization that prepares statutory financial statements for submission to its state of domicile, such annual and/or quarterly statutory financial statements shall be filed with the commissioner. In the event the health organization fails to comply with a request of the commissioner pursuant to this section, the commissioner shall have the power to suspend or revoke the license of the health organization and/or to examine the controlling affiliate or person.

(g) As used in this section, the term "control" including "controlling," and the terms "affiliate" and "person" shall have the meanings ascribed to them in section 27-35-1. The term "health organization" shall have the meaning ascribed to it

in section 27-4.7-2.

SECTION 13. Section 27-19-29 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby amended to read as follows:

27-19-29. ~~Control, merger, or consolidation.~~ Holding company systems. -- ~~No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire on the open market or otherwise, any voting security or other indicia of ownership of a nonprofit hospital service corporation or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by the exercise of any right to acquire, be in control of the nonprofit hospital service corporation, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a nonprofit hospital service corporation, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition if no offer or agreement is involved, the person has filed with the director of business regulation and the attorney general, and has sent to the nonprofit hospital service corporation, the information required by section 27-35-2, and the offer, request, invitation, agreement or acquisition has been approved by the director. Approval by the director of business regulation shall be made in accordance with the standards set forth in section 27-35-2. That approval shall not supersede any other approval under Rhode Island law relative to mergers or other acquisitions of nonprofit hospital service corporations in their capacity as Rhode Island charitable nonprofit corporations.~~ Except to the extent superceded by chapter 27-64, all of the provisions of chapter 27-35 shall apply to corporations organized or licensed pursuant to this chapter.

SECTION 14. Section 27-20-25 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby amended to read as follows:

27-20-25. ~~Control, merger, or consolidation.~~ Holding company systems. -- ~~No person may take a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire on the open market or otherwise, any voting security or other indicia of ownership of a nonprofit medical service corporation or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the nonprofit medical service corporation, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a nonprofit medical service corporation, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition if no offer or agreement is involved, the person has filed with the director of business regulation and the attorney general, and has sent to the nonprofit medical service corporation, the information required by section 27-35-2 and the offer, request, invitation, agreement or acquisition has been approved by the director. Approval by the director of business regulation shall be made in accordance with the standards set forth in section 27-35-2. That approval shall not supersede any other approval under Rhode Island law relative to mergers or other acquisitions of nonprofit medical service corporations in their capacity as Rhode Island charitable nonprofit corporations.~~ Except to the extent superceded by chapter 27-64, all of the provisions of chapter 27-35 shall apply to corporations organized or licensed pursuant to this chapter.

SECTION 15. Section 27-20.1-12 of the General Laws in Chapter 27-20.1 entitled "Nonprofit Dental Service Corporations" is hereby amended to read as follows:

27-20.1-12. ~~Control, merger, or consolidation.~~ Holding company systems. -- ~~No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire on the open market or otherwise, any voting security or other indicia of ownership of a nonprofit dental service corporation or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the nonprofit dental service corporation, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a nonprofit dental service corporation, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition if no offer or agreement is involved, the person has filed with the director of business regulation and the attorney general, and has sent to the nonprofit dental service corporation, the information required by section 27-35-2 and the offer, request, invitation, agreement, or acquisition has been approved by the director. Approval by the director of business regulations shall be made in accordance with the standards set forth in section 27-35-2.~~ All of the provisions of chapter

27-35 shall apply to corporations organized or licensed pursuant to this chapter. ~~That~~ Any approval granted by the director pursuant to chapter 27-35 shall not supersede any other approval under Rhode Island law relative to mergers or other acquisitions of nonprofit dental service corporations in their capacity as Rhode Island charitable nonprofit corporations.

SECTION 16. Section 27-20.2-12 of the General Laws in Chapter 27-20.2 entitled "Nonprofit Optometric Service Corporations" is hereby amended to read as follows:

27-20.2-12. ~~Control, merger, or consolidation~~ Holding company systems. -- ~~No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire on the open market or otherwise, any voting security or other indicia of ownership of a nonprofit optometric service corporation, or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the nonprofit optometric service corporation, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a nonprofit optometric service corporation, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition if no offer or agreement is involved, the person has filed with the director of business regulation and the attorney general, and has sent to the nonprofit optometric service corporation, the information required by section 27-35-2 and the offer, request, invitation, agreement, or acquisition has been approved by the director. Approval by the director of business regulation shall be made in accordance with the standards set forth in section 27-35-2.~~ All of the provisions of chapter 27-35 shall apply to corporations organized or licensed pursuant to this chapter. ~~That~~ Any approval granted by the director pursuant to chapter 27-35 shall not supersede any other approval under Rhode Island law relative to mergers or other acquisitions of nonprofit optometric service corporations in their capacity as Rhode Island charitable nonprofit corporations.

SECTION 17. Section 27-20.3-12 of the General Laws in Chapter 27-20.3 entitled "Nonprofit Legal Service Corporations" is hereby amended to read as follows:

27-20.3-12. ~~Control, merger, or consolidation.~~ Holding company systems. -- ~~No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire on the open market or otherwise, any voting security or other indicia of ownership of a nonprofit legal service corporation, or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the nonprofit legal service corporations, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a nonprofit legal service corporation, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition if no offer or agreement is involved, the person has filed with the director of business regulation, and has sent to the nonprofit legal service corporation, the information required by section 27-35-2 and the offer, request, invitation, agreement or acquisition has been approved by the director. Approval by the director of business regulation shall be made in accordance with the standards set forth in section 27-35-2 of the general laws.~~ All provisions of chapter 27-35 shall apply to corporations organized or licensed pursuant to this chapter. ~~That~~ Any approval granted by the director pursuant to chapter 27-35 shall ~~be in lieu of and~~ not supersede any other approval under Rhode Island law relative to mergers or other acquisitions of nonprofit legal service corporations in their capacity as Rhode Island charitable nonprofit corporations.

SECTION 18. Section 27-35-1 of the General Laws in Chapter 27-35 entitled "Insurance Holding Company Systems" is hereby amended to read as follows:

27-35-1. Definitions. -- (a) Affiliate. - An "affiliate" of, or person "affiliated" with, a specific person, is a person who directly or indirectly through one or more intermediaries controls, or is controlled by, or is under common control with, the person specified. An "affiliate" does not include a protected cell of a protected cell company organized under the Protected Cell Companies Act of this title.

(b) Commissioner. - The term "commissioner" shall mean the insurance commissioner, and any assistant to the insurance commissioner designated and authorized by him or her while acting under that designation.

(c) Control. - The term "control", including the terms "controlling," "controlled by" and "under common control with",

means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by section 27-35-3(i) that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support that determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(d) Insurance holding company system. - An "insurance holding company system" consists of two (2) or more affiliated persons, one or more of which is an insurer.

(e) Insurer. - The term "insurer" shall mean any person or persons or corporation, partnership or company authorized by the laws of this state to transact the business of insurance in this state, including entities organized or authorized to transact business in this state pursuant to chapters 27-19, 27-20, 27-20.1, 27-20.2, 27-20.3 and 27-41, except that it shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(f) Person. - A "person" is an individual, corporation, partnership, association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing acting in concert, but shall not include any securities broker performing no more than the usual and customary broker's function.

(g) Securityholder. - A "securityholder" of a specified person is one who owns any security of the person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

(h) Subsidiary. - A "subsidiary" of a specified person is an affiliate controlled by the person directly, or indirectly through one or more intermediaries.

(i) Voting security. - The term "voting security" shall include any security convertible into or evidencing a right to acquire a voting security.

SECTION 19. Section 27-41-25 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby amended to read as follows:

27-41-25. ~~Acquisition of control of or merger of a health maintenance organization.~~ Holding company systems. -- ~~No person may take a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the director and the attorney general, and has sent to the health maintenance organization, information required by section 27-35-2 and the offer, request, invitation, agreement, or acquisition has been approved by the director. Approval by the director shall be governed by section 27-35-2.~~ Except to the extent superceded by chapter 27-64, all of the provisions of chapter 27-35 shall apply to corporations organized or licensed pursuant to this chapter.

SECTION 20. Section 27-19-6 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby amended to read as follows:

27-19-6. Rates charged subscribers - Reserves. -- The rates proposed to be charged by any corporation organized under this chapter to its subscribers shall be filed by the corporation at the office of the director of business regulation. Within thirty (30) days after receipt of the application, the director shall hold a hearing upon not less than ten (10) days

written notice prior to the hearing. The notice shall contain a description of the rates proposed to be charged and a copy of the notice shall be sent to the applicant and to the Rhode Island ~~consumer's council~~ department of the attorney general. At any hearing held under this section, the applicant shall be required to establish that the rates proposed to be charged to subscribers are consistent with the proper conduct of its business and with the interest of the public. Rates proposed to be charged by any corporation organized under this chapter shall be sufficient to maintain total reserves in a dollar amount sufficient to pay claims and operating expenses for not less than one month ~~nor more than three (3) months~~. Those reserves shall be computed as of each December 31st, and a report setting forth the computation shall be submitted to the director of the department of business regulation together with the corporation's Rhode Island annual statement to the insurance commissioner. Any documents presented in support of a filing of proposed rates under this section shall be made available for inspection by any party entitled to participate in a hearing provided under this section at a time and at a place as the director may deem reasonable. The director, upon the hearing, may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he or she deems relevant. The director shall issue a decision as soon as is reasonably possible following the completion of the hearing. The decision may approve, disapprove, or modify the rates proposed to be charged by the applicant.

SECTION 21. Section 27-20-6 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby amended to read as follows:

27-20-6. Rates charged subscribers -- Reserves -- Hearing by director. -- The rates proposed to be charged by any corporation organized under this chapter to its subscribers shall be filed by the corporation at the office of the director of business regulation. Within thirty (30) days after receipt of the application, the director shall hold a hearing upon not less than ten (10) days written notice prior to the hearing. The notice shall contain a description of the rates proposed to be charged and a copy of the notice shall be sent to the applicant and to the Rhode Island ~~consumer's council~~ department of the attorney general. At any hearing held hereunder, the applicant shall be required to establish that the rates proposed to be charged to subscribers are consistent with the proper conduct of its business and with the interest of the public. Rates proposed to be charged by any corporation organized under this chapter shall maintain total reserves in a dollar amount sufficient to pay claims and operating expenses for not less than one month ~~nor more than three (3) months~~. Those reserves shall be computed as of each December 31st, and a report setting forth the computation shall be submitted to the director of the department of business regulation together with the corporation's Rhode Island annual statement to the insurance commissioner of the state of Rhode Island. Any documents presented in support of a filing of proposed rates hereunder shall be made available for inspection by any party entitled to participate in a hearing provided hereunder at a time and at a place as the director may deem reasonable. The director, upon the hearing, may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which the director deems relevant. The director shall issue a decision as soon as is reasonably possible following completion of the hearing. The decision may approve, disapprove, or modify the rates proposed to be charged by the applicant.

SECTION 22. This act shall take effect on July 1, 2000."

Respectfully submitted,

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REPRESENTATIVE BENOIT

CONSENT CALENDAR

In order for Friday, June 30, 2000:

1.(2000-H 8294) An Act relating to property subject to taxation.

Committee on Corporations recommends passage.

LOUIS D'ANTUONO
Reading Clerk
Tuesday, June 27, 2000

Appendix

CALENDAR

In order for Wednesday, June 28, 2000:

1. (00-S 2587 as amended) An Act relating to the retirement system - membership and service credits.

Ordered on the Calendar.

2. (00-S 2572) (Substitute "A") Joint Resolution requesting the Department of Elementary and Secondary Education in Partnership with the Department of Health and Department of Mental Health, Retardation and Hospitals to encourage the establishment of emotional and social competency learning programs in local school districts.

Committee on Health, Education and Welfare recommends indefinite postponement of the original bill and passage of Substitute "A".

3.(00-S 2525) An Act relating to health and safety.

Committee on Corporations recommends passage in concurrence.

Appendix

CALENDAR In order for Friday, June 30, 2000:

1.(2000-H 7580) (Substitute "A") An Act relating to use of vehicles by law enforcement officers.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

2.(2000-H 8249) (Substitute "A") House Resolution creating a special House commission to study motor vehicle noise pollution.

Committee on Judiciary recommends indefinite postponement of the original bill and passage of Substitute "A".

3.(2000-H 8373) An Act relating to criminal procedure - mandatory protection and supervision of witnesses.

Committee on Judiciary recommends passage.

4.(2000-H 7692) An Act relating to exchange of information in support of child support collection.

Committee on Judiciary recommends passage.

5.(2000-H 6727 as amended) An Act relating to businesses and professions - telephone sales solicitation.

Committee on Judiciary recommends passage as amended.

6.(2000-H 8319) (Substitute "A".' An Act relating to businesses and professions immunity from civil liability to architects, engineers, land surveyors and landscape architects.

Committee on Judiciary recommends indefinite postponement of the original bill and passage of Substitute "A".

(2000-H 8279) (Substitute "A") An Act relating to pharmacy.

Committee on Corporations recommends indefinite postponement of the original bill and passage of Substitute "A".

8.(2000-H 8179) (Substitute "A") An Act relating to the state building and fire code.

Committee on Corporations recommends indefinite postponement of the original bill and passage of Substitute "A".

9.(2000-H 7772) (Substitute "A") An Act relating to public buildings - public property and works.

Committee on Corporations recommends indefinite postponement of the original bill and passage of Substitute "A".

10.(2000-H 8352) An Act to vacate the forfeiture or revocation of the charter of Hurdis Drilling Co., Inc.

Committee on Corporations recommends passage.

11.(2000-H 8256) (Substitute "A") An Act relating to insurance.

Committee on Corporations recommends indefinite postponement of the original bill and passage of Substitute "A".

12.(2000-H 7342) (Substitute "A") An Act relating to sexual offender registration.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

13. (2000-H 7350) (Substitute "A") An Act relating to courts and civil procedure Family Court.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

14.(2000-H 7501) (Substitute "A") An Act relating to state affairs and government state lottery.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

15.(2000-H 8222) (Substitute "A") An Act relating to the Board of Governors for Higher Education research positions.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

16.(2000-H 7925) (Substitute "A") An Act relating to taxation - declaration of estimated tax by corporation.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

17.(2000-H 7018) (Substitute "A") An Act relating to children.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

18.(2000-H 7954) (Substitute "A") House Resolution creating a special House commission to study the feasibility of providing cable television to the town of Foster.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

19.(2000-H 7159) (Substitute "A") An Act relating to human services - health care for elderly and disabled residents.

Committee on Finance recommends indefinite postponement of the original bill and passage of Substitute "A".

20.(2000-H 7199) An Act relating to the Pharmaceutical Assistance to the Elderly Act.

Committee on Finance recommends passage.

21.(2000-H 7425) An Act relating to labor and labor relations.

Committee on Finance recommends passage.

22.(2000-H 7136) An Act relating to public assistance.

Committee on Finance recommends passage.

23.(2000-H 8331) An Act relating to health insurance - premium assessments.

Committee on Finance recommends passage.

24.(00-S 3006) An Act making an appropriation to pay certain claims.

Ordered on the Calendar.

25.(00-S 2130) (Substitute "A") An Act relating to property- aircraft repair liens.

Committee on Judiciary recommends indefinite postponement of the original bill and passage of Substitute "A" in concurrence.

26.(00-S 2208) Joint Resolution creating a special legislative commission to study services to persons with mental illness in the criminal justice system.

Committee on Judiciary recommends passage in concurrence.

27.(00-S 2327) An Act relating to exchange of information in support of child support collection.

Committee on Judiciary recommends passage in concurrence.

28.(00-S 2338) An Act relating to highways - freeways.

Committee on Judiciary recommends passage in concurrence.

29.(00-S 2514) An Act relating to the Rhode Island Whistleblowers' Protective Act.

Committee on Judiciary recommends passage in concurrence.

30.(00-S 2547) (Substitute "A") An Act relating to businesses and professions health care communications.

Committee on Judiciary recommends indefinite postponement of the original bill and passage of Substitute "A" in concurrence.

31.(00-S 2431) (Substitute "A") An Act relating to animals- cruelty to animals.

Committee on Judiciary recommends indefinite postponement of the original bill and passage of Substitute "A" in concurrence.

32.(00-S 2470) (Substitute "B',) An Act relating to motor vehicle offenses.

Committee on Judiciary recommends indefinite postponement of the original bill and the bill marked Substitute "A" and passage of Substitute "B".

33.(00-S 2645) An Act relating to public officers and employees.

Committee on Judiciary recommends passage in concurrence.

34.(00-S 2704) (Substitute "A") An Act relating to criminal offenses sex offender central registry.

Committee on Judiciary recommends indefinite postponement of the original bill and passage of Substitute "A" in concurrence.

35.(00-S 3044) An Act relating to solemnization of marriage.

Committee on Judiciary recommends passage in concurrence.

36.(00-S 2966) (Substitute "B,,) An Act relating to motor and other vehicles.

Committee on Judiciary recommends indefinite postponement of the original bill and the bill marked Substitute "A" and passage of Substitute 'B"

37.(00-S 2638) (Substitute "A") An Act relating to taxation cigarette tax.

Committee on Judiciary recommends indefinite postponement of the original bill and passage of Substitute "A" in concurrence.

38.(00-S 2241) (Substitute "A") An Act relating to mental health law.

Committee on Judiciary recommends indefinite postponement of the original bill and passage of Substitute "A" in concurrence.

39.(00-S 2770) (Substitute "A" as amended) An Act relating to indictments, informations and complaints.

Committee on Judiciary recommends indefinite postponement of the original bill and passage of Substitute "A" as amended in concurrence.

40.(00-S 2114) (Substitute "A") An Act relating to highways- construction and maintenance.

Committee on Corporations recommends indefinite postponement of the original bill and passage of Substitute "A" in concurrence.

41.(00-S 2991) An Act relating to property subject to taxation.

Committee on Corporations recommends passage in concurrence.

42. (00-S 2987) An Act exempting from taxation the real, mixed and personal property of the Burrillville Glocester Youth Soccer Association, Inc.

Committee on Corporations recommends passage in concurrence.

43.(00-S 2992) An Act relating to levy and assessment of local taxes.

Committee on Corporations recommends passage in concurrence.

44. (00-S 3007) An Act authorizing the town of Lincoln to issue general obligation bonds and notes in an amount not to exceed one million dollars for the purpose of acquiring and preserving open space and acquiring, preserving, constructing or improving recreational areas or facilities in the town.

Committee on Corporations recommends passage in concurrence.

45.(00-S 2474) An Act relating to insurance - agents, brokers and solicitors.

Committee on Corporations recommends passage in concurrence.

46. (00-S 3009) An Act authorizing the city of Cranston to finance the renovation, rehabilitation, repair, improvement, furnishing and equipping of schools and school facilities including, but not limited to, additions to Cranston High School East and the Western Hills Middle School and improvements to the Park View Middle School in the city by the issuance of not more than $13,865,000 bonds and notes therefor.

Committee on Corporations recommends passage in concurrence.

47. (00-S 3012) An Act authorizing the city of Cranston to finance the construction, furnishing and equipping of a new police station in the city including land acquisition by the issuance of not more than $13,100,000 bonds and notes therefor.

Committee on Corporations recommends passage in concurrence.

48.(00-S 2631) An Act relating to insurance.

Committee on Corporations recommends passage in concurrence.

49.(00-S 2486) (Substitute "A") An Act relating to professional service corporations.

Committee on Corporations recommends indefinite postponement of the original bill and passage of Substitute "A".

50.(00-S 2483) (Substitute "A" as amended) An Act relating to the hospital conversions act.

Committee on Corporations recommends indefinite postponement of the original bill and passage of Substitute "A" as amended in concurrence.

51. (00-S 3013) An Act authorizing the city of Cranston to finance the acquisition and preservation of open space by the issuance of not more than $1,000,000 bonds and notes therefor.

Committee on Corporations recommends passage in concurrence.

52.(00-S 2344) An Act relating to businesses and professions- psychologists.

Committee on Corporations recommends passage in concurrence.

53. (00-S 3008) An Act authorizing the city of Cranston to finance the acquisition, construction, improvement, renovation, alteration, repair and equipping of infrastructure including, but not limited to, protective improvements to the city's shoreline along Narragansett Bay, sidewalk, highway and traffic control improvements, landscaping and lighting by the issuance of not more than $4,000,000 bonds and notes therefor.

Committee on Corporations recommends passage in concurrence.

54. (00-S 3010) An Act authorizing the city of Cranston to finance the construction, reconstruction and installation of storm drains and the acquisition of public works equipment necessary for storm drain operation by the issuance of not more than $900,000 bonds and notes therefor.

Committee on Corporations recommends passage in concurrence.

55.(00-S 3040) An Act to vacate the forfeiture or revocation of the charter of One Stop Hardware of Providence, Inc.

Committee on Corporations recommends passage in concurrence.

56.(00-S 2665) An Act relating to incorporation of United Electric Power Company.

Committee on Corporations recommends passage in concurrence.

57.(00-S 2912) An Act relating to cities and towns.

Committee on Corporations recommends passage in concurrence.

58. (00-S 2677 as amended) An Act authorizing the city of Providence to issue bonds and notes in an amount not exceeding fifty million (.$50,000,000) dollars for the purpose of redevelopment and"or capital improvements.

Committee on Corporations recommends passage as amended in concurrence.

59.(00-S 2569 as amended) An Act relating to state affairs and government - electronic signatures and records act.

Committee on Corporations recommends passage as amended in concurrence.

60.(00-S 2434 as amended) An Act relating to tree wardens.

Committee on Corporations recommends passage as amended in concurrence.

61.(00-S 2580) An Act relating to businesses and professions plumbers.

Committee on Labor recommends passage in concurrence.

62.(00-S 2593) An Act relating to labor and labor relations- Division of Professional Regulation.

Committee on Labor recommends passage in concurrence.

63.(00-S 2643) (Substitute "B") An Act relating to criminal offenses - sexual offender registration and community notification.

Committee on Finance recommends indefinite postponement of the original bill and the bill marked Substitute "A" and passage of Substitute "B".

64.(00-S 2329) An Act making an appropriation of $5,000 to Laura A. Hoxsie.

Committee on Finance recommends passage in concurrence.

LOUIS D'ANTUONO
Reading Clerk
Tuesday, June 27, 2000

As always, your comments concerning this page are welcomed and appreciated.

Thank you for stopping by!