Hall of the House of Representatives

84th General Assembly - Regular Session, 2003

Amendment Form

* *

Subtitle of House Bill No. 2279

"TO PROVIDE ADDITIONAL FUNDING TO THE ARKANSAS COMPREHENSIVE HEALTH INSURANCE POOL THROUGH A SURCHARGE OF PAYMENTS BY INSURERS AND SELF-INSURED HEALTH PLANS FOR INPATIENT HOSPITAL SERVICES."

* *

Amendment No. 1 to House Bill No. 2279.

Amend House Bill No. 2279 as originally introduced:

Page 1, delete the Title and substitute the following:
"AN ACT TO EXTEND HEALTH INSURANCE POOL ELIGIBILITY TO INDIVIDUALS WHO ARE ELIGIBLE FOR TAX CREDITS FOR HEALTH INSURANCE COVERAGE UNDER THE TRADE ADJUSTMENT ASSISTANCE REFORM ACT OF 2002; TO MAKE THE POOL ELIGIBLE FOR FEDERAL FUNDS TO OFFSET LOSSES TO THE POOL; AND FOR OTHER PURPOSES."

AND

Page 1, delete the Subtitle and substitute the following:
"TO EXTEND POOL ELIGIBILITY TO INDIVIDUALS WHO ARE ELIGIBLE FOR CERTAIN FEDERAL TAX CREDITS FOR HEALTH INSURANCE COVERAGE; TO MAKE THE POOL ELIGIBLE FOR FEDERAL FUNDS TO OFFSET LOSSES TO THE POOL."

AND

Page 1, delete everything after the enacting clause and substitute the following:

"SECTION 1. Arkansas Code § 23-79-501, relating to the purpose of the Act, is amended to read as follows:

23-79-501. Purpose.

(a)(1) Act 1339 of 1995 established the Arkansas Comprehensive Health Insurance Pool as a state program that was intended to provide an alternate market for health insurance for certain uninsurable Arkansas residents, and further this subchapter is intended to provide for the successor entity that will provide the acceptable alternative mechanism as described in the federal Health Insurance Portability and Accountability Act of 1996 for providing portable and accessible individual health insurance coverage for federally eligible individuals as defined in this subchapter.

(2) This subchapter further is intended to provide a health insurance coverage option for persons eligible for a federal income tax

credit under section 35 of the Internal Revenue Code, as created by the Trade Adjustment Assistance Reform Act of 2002 or as subsequently amended.

(b) The General Assembly declares that it intends for this program to provide portable and accessible individual health insurance coverage for every ~~federally eligible~~ individual who qualifies for coverage in accordance with § 23-79-509(b) as a federally eligible individual or as a qualified trade adjustment assistance eligible person, but does not intend for every eligible person who qualifies for pool coverage in accordance with § 23-79-509 to be guaranteed a right to be issued a policy under this pool as a matter of entitlement.

SECTION 2. Arkansas Code § 23-79-503, relating to Definitions, is amended to read as follows:

23-79-503. Definitions.

For the purposes of this subchapter, the following definitions apply:

(1) "Agent" means any person who is licensed to sell health insurance in this state;

(2) "Board" means the Board of Directors of the Arkansas Comprehensive Health Insurance Pool;

(3) "Church plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;

(4) "Commissioner" means the Insurance Commissioner for the State of Arkansas;

(5) "Continuation coverage" means continuation of coverage under a group health plan or other health insurance coverage for former employees or dependents of former employees that would otherwise have terminated under the terms of that coverage pursuant to any continuation provisions under federal or state law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, § 23-86-114 of the Arkansas Insurance Code, § 23-60-101 et seq., or any other similar requirement in another state;

(6) "Covered person" means a person who is and continues to remain eligible for pool coverage and is covered under one (1) of the plans offered by the pool;

(7)(A) "Creditable coverage" means, with respect to a federally eligible individual or a qualified trade adjustment assistance eligible person, coverage of the individual under any of the following:

(i) A group health plan;

(ii) Health insurance coverage, including group health insurance coverage;

(iii) Medicare;

(iv) Medical assistance;

(v) 10 U.S.C. § 1071 et seq.;

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

(vii) A state health benefits risk pool;

(viii) A health plan offered under 5 U.S.C. § 8901 et seq.;

(ix) A public health plan, as defined in regulations consistent with § 104 of the Health Care Portability and Accountability Act of 1996 that may be promulgated by the Secretary of the Department of Health and Human Services; and

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

(B) Creditable coverage does not include:

(i) Coverage consisting solely of coverage of excepted benefits as defined in § 2791(C) of Title XXVII of the Public Health Services Act, 42 U.S.C. § 300(gg-91); or

(ii)(a) Any period of coverage under subdivisions (7)(A)(i)-(x) of this section that occurred before a break of more than sixty-three (63) days during all of which the individual was not covered under subdivisions (7)(A)(i)-(x) of this section.

(b) 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 under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into account in determining if there has been a break of more than sixty-three (63) days in any creditable coverage;

(8) "Department" means the State Insurance Department;

(9) "Excess or stop-loss coverage" means an arrangement whereby an insurer insures against the risk that any one (1) claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount;

(10) "Federally eligible individual" means an individual resident of Arkansas:

(A)(i) For whom, as of the date on which the individual seeks pool coverage under § 23-79-509, the aggregate of the periods of creditable coverage is eighteen (18) or more months; and

(ii) Whose most recent prior creditable coverage was under group health insurance coverage offered by an insurer, a group health plan, a governmental plan, or a church plan, or health insurance coverage offered in connection with any such plans;

(B) Who is not eligible for coverage under:

(i) A group health plan;

(ii) Part A or Part B of Medicare; or

(iii) Medical assistance and does not have other health insurance coverage;

(C) With respect to whom the most recent coverage within the coverage period described in subdivision (10)(A)(i) of this section was not terminated based upon a factor related to nonpayment of premiums or fraud;

(D) If the individual has been offered the option of continuation coverage under a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation provision or under a similar state program, who elected such coverage; and

(E) Who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program;

(11) "Group health plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;

(12) "Governmental plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;

(13)(A) "Health insurance" means any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer,

hospital or medical service corporation, health maintenance organization, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, and includes any excess or stop-loss coverage.

(B) The term does not include long-term care, disability income, short-term, accident, dental-only, vision-only, fixed indemnity, limited-benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(14) "Health maintenance organization" shall have the same meaning as defined in § 23-76-102;

(15) "Hospital" shall have the same meaning as defined in § 20-9-201;

(16) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance;

(17) "Insurer" means any entity that provides health insurance, including excess or stop-loss health insurance in the State of Arkansas. For the purposes of this subchapter, "insurer" includes an insurance company, medical services plans, hospital plans, hospital medical service corporations, health maintenance organizations, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(18) "Medical assistance" means the state medical assistance program provided under Title XIX of the Social Security Act or under any similar program of health care benefits in a state other than Arkansas;

(19)(A) "Medically necessary" means that a service, drug, supply, or article is necessary and appropriate for the diagnosis or treatment of an illness or injury in accord with generally accepted standards of medical practice at the time the service, drug, or supply is provided. When specifically applied to a confinement it further means the diagnosis or treatment of the covered person's medical symptoms or condition cannot be safely provided to that person as an outpatient.

(B) A service, drug, supply, or article shall not be medically necessary if it:

(i) Is investigational, experimental, or for research purposes;

(ii) Is provided solely for the convenience of the patient, the patient's family, physician, hospital, or any other provider;

(iii) Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;

(iv) Could have been omitted without adversely affecting the covered person's condition or the quality of medical care; or

(v) Involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration;

(20) "Medicare" means coverage under Part A and Part B of Title XVII of the Social Security Act, 42 U.S.C. § 1395 et seq.;

(21) "Physician" means a person licensed to practice medicine as duly licensed by the State of Arkansas;

(22) "Plan" means the comprehensive health insurance plan as adopted by the board or by rule;

(23) "Plan administrator" means the insurer designated under § 23-79-508 to carry out the provisions of the plan of operation;

(24) "Plan of operation" means the plan of operation of the pool, including articles, bylaws, and operating rules adopted by the board pursuant to this subchapter;

(25) "Provider" means any hospital, skilled nursing facility, hospice, home health agency, physician, pharmacist, or any other person or entity licensed in Arkansas to furnish medical care, articles and supplies;

(26) "Qualified high risk pool" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996; ~~and~~

(27) "qualified trade adjustment assistance eligible person" means a person who is a trade adjustment assistance eligible person as defined by this section and for whom, on the date an application for the individual is received by the pool under § 23-79-509, has an aggregate of at least three (3) months of creditable coverage without a break in such coverage of sixty-three (63) days or more;

~~(27)~~(28) "Resident eligible person" means a person who:

(A) Has been legally domiciled in the State of Arkansas ~~for~~:

(i) For a period of at ~~least thirty (30) days~~ one (1) year and continues to be domiciled in Arkansas; ~~and~~ or

(ii) For a period of at least thirty (30) days, continues to be domiciled in Arkansas, and was covered under a Qualified High Risk Pool in another state up until sixty-three (63) days or less prior to the date that the pool receives his or her application for coverage; and

(B) Is not eligible for coverage under:

(i) A group health plan;

(ii) Part A or Part B of Medicare; or

(iii) Medical assistance as defined in this section and does not have other health insurance coverage as defined in this section~~.~~; and

(29) "Trade adjustment assistance eligible person" means a person who is legally domiciled in the State of Arkansas on the date of application to the pool and is eligible for the tax credit for health insurance coverage premiums under section 35 of the Internal Revenue Code of 1986.

SECTION 3. Arkansas Code § 23-79-507, relating to the funding of the pool, is amended to read as follows:

23-79-507. Funding of pool.

(a) Premiums.

(1) The Arkansas Comprehensive Health Insurance Pool shall establish premium rates for plan coverage as provided in subdivision (a)(2) of this section. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the Insurance Commissioner for approval prior to use.

(2)(A) The pool, with the assistance of the commissioner, shall determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals in Arkansas. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage.

(B) ~~Initial rates~~ Rates for plan coverage shall not ~~be less than~~ exceed one hundred fifty percent (150%) of rates established as applicable for individual standard risks in Arkansas. Subject to the limits provided in this subdivision (a)(2), subsequent rates shall be established to help provide for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. ~~In no event shall plan rates exceed two hundred percent (200%) of rates applicable to individual standard risks.~~

(b) Sources of Additional Revenue.

(1) In addition to the powers enumerated in § 23-79-506, the pool shall have the authority to assess insurers in accordance with the provisions of this section and to make advance interim assessments as may be reasonable and necessary for the pool's organizational and interim operating expenses. Any such interim assessments ~~are to~~ may be credited as offsets against any regular assessments due following the close of the fiscal year.

(2) Following the close of each fiscal year, the plan administrator shall determine the net premiums, i.e., premiums less administrative expense allowances, the pool expenses of administration and operation and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. The deficit incurred by the pool not otherwise recouped under subdivisions (b)(9) or (e) of this section shall be recouped by assessments apportioned by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool among insurers.

(3) Each insurer's assessment shall be determined by multiplying the total assessment of all insurers as determined in subdivision (b)(2) of this section by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all health insurance premiums by all insurers.

(4) If assessments or other funds received under subdivisions (b)(9) or (e) of this section or any combination of the assessments and funds exceed the pool's actual losses and administrative expenses, the excess shall be held at interest and used by the board to offset future losses or to reduce future assessments. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(5) Each insurer's assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board or the commissioner.

(6)(A) An insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer, in whole or in part, the assessment if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations.

(B) In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which the assessment is

abated or deferred shall be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this subsection. The insurer receiving the abatement or deferment shall remain liable to the plan for the deficiency for four (4) years.

(7) ~~From July 1, 1997, until December 31, 1997, if the board issues an assessment upon insurers, the board will utilize the method of calculating the assessment consistent with the provisions set forth in this subchapter, provided however, for purposes of this interim period assessment, insurers shall be defined as any individual, corporation, association, partnership, fraternal benefits society, or any other entity engaged in the health insurance business, except insurance agents or brokers. This term shall also include medical services plans, hospital plans, health maintenance organizations, and self-insurance arrangements, which shall be designated as engaged in the business of insurance for the purposes of this interim period assessment.~~ For all assessments issued by the board, beginning January 1, 1998, only those individuals, corporations, associations, or other entities defined as an insurer in § 23-79-503(17) shall be subject to assessment.

(8) In the event the board fails to act within a reasonable period of time to recoup by assessment any deficit incurred by the pool, the commissioner shall have all the powers and duties of the board under this chapter with respect to assessing insurers.

(9) The General Assembly further intends that the Comprehensive Health Insurance Pool be eligible for, and for the pool, its board, or other officers of state government, as appropriate, to take steps necessary to obtain, federal grant funds to offset losses of the pool, including such funds made available under the Trade Adjustment Assistance Reform Act of 2002.

(c) Assessment Offsets.

(1)(A) Any assessment may be offset in an amount equal to the amount of the assessment paid to the pool against the premium tax payable by that insurer for the year in which the assessment is levied or for the four (4) years subsequent to that year.

(B) No offset shall be allowed for any penalty assessed under subdivision (d)(1) of this section.

(2) Notwithstanding any provisions of this subchapter to the contrary, no insurer may be assessed in any one (1) calendar year an amount greater than the amount which that insurer paid to the state in the previous year as premium tax on the business to which this tax applies, or one-hundredth of one percent (0.01%) of the total written premiums on the business in this state, whichever is greater.

(d)(1) All assessments and fees shall be due and payable upon receipt and shall be delinquent if not paid within thirty (30) days of the receipt of the notice by the insurer. Failure to timely pay the assessment will automatically subject the insurer to a ten percent (10%) penalty, which will be due and payable within the next thirty-day period. The board and the commissioner shall have the authority to enforce the collection of the assessment and penalty in accordance with the provisions of this subchapter and the Arkansas Insurance Code, § 23-60-101 et seq. The board may waive the penalty authorized by this subsection if it determines that compelling circumstances exist which justify such waiver.

(2) The board and the commissioner shall have the authority to enforce the collection of the assessment and penalty in accordance with the

provisions of this subchapter and the Arkansas Insurance Code, § 23-60-101 et seq. The board may waive the penalty authorized by this subsection if it determines that compelling circumstances exist which justify the waiver.

(e) Payment from the State Insurance Department Trust Fund.

(1)(A) Following the close of each fiscal year, the board and the plan administrator shall determine whether the pool has incurred a deficit as calculated under subdivision (b)(2) of this section.

(B) If a deficit under subdivision (b)(2) of this section has been incurred, the State Insurance Department shall, during the next fiscal year, transfer for deposit into the pool, from the State Insurance Department Trust Fund, in equal quarterly installments, a sum equal to the deficit from those funds in the State Insurance Department Trust Fund that are in excess of the amount needed to meet the requirements of the approved annual budget for the applicable fiscal year but not to exceed eight million dollars ($8,000,000).

(2) For any fiscal year in which the board and the plan administrator determine that the pool did not incur a deficit as calculated under subdivision (b)(2) of this section, the State Insurance Department shall not, during the following fiscal year, transfer any funds to the pool from the State Insurance Department Trust Fund under subdivision (e)(1)(B) of this section.

SECTION 4. Arkansas Code § 23-79-509, relating to the plan eligibility, is amended to read as follows:

23-79-509. Plan eligibility.

(a) ~~Resident Eligible Person~~ General Eligibility Requirements. The following requirements apply to a resident eligible person or a trade adjustment assistance eligible person in order for the person to be eligible for plan coverage:

(1) Except as provided in subdivision (a)(2) or subsection (b) of this section, any individual person who meets the definition of resident eligible person as defined by ~~§ 23-79-503(27)~~ § 23-79-503(28), or a trade adjustment assistance eligible person as defined by § 23-79-503(29), and is either a citizen of the United States or an alien lawfully admitted for permanent residence who continues to be a resident of this state shall be eligible for plan coverage if evidence is provided of:

(A) A notice of rejection or refusal by an insurer to issue substantially similar individual health insurance coverage by reason of the existence or history of a medical condition or upon such other evidence the Board of Directors of the Arkansas Comprehensive Health Insurance Pool deems sufficient in order to verify that the applicant is unable to obtain the coverage from an insurer due to the existence or history of a medical condition; or

(B)(i) A refusal by an insurer to issue individual health insurance coverage, except at a rate which the board determines is substantially in excess of the applicable plan rate.

(ii) A rejection or refusal by a group health plan or insurer offering only stop-loss or excess-of-loss insurance or contracts, agreements, or other arrangements for reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection; or

(C) Evidence that the applicant was covered under a Qualified High Risk Pool of another state, provided the coverage terminated

no more than sixty-three (63) days prior to the date the pool receives the applicant's application for coverage, and the other state's Qualified High Risk Pool did not terminate the person's coverage for fraud;

(2) A person shall not be eligible for coverage under the plan if:

(A) The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy or would be eligible to have coverage if the person elected to obtain it, except that:

(i) A person may maintain other coverage for the period of time the person is satisfying any waiting period for a preexisting condition under a plan policy; and

(ii) A person may maintain plan coverage for the period of time the person is satisfying a waiting period for a preexisting condition under another health insurance policy intended to replace the plan policy;

(B) The person is determined to be eligible for health care benefits under Title XIX of the Social Security Act;

(C) The person has previously terminated plan coverage unless twelve (12) months have elapsed since termination of coverage;

(D) The person fails to pay the required premium under the covered person's terms of enrollment and participation, in which event the liability of the plan shall be limited to benefits incurred under the plan for the same period for which premiums had been paid and the covered person remained eligible for plan coverage;

(E) The plan has paid a total of one million dollars ($1,000,000) in benefits on behalf of the covered person;

(F) The person is a resident of a public institution; or

(G) The person's premium is paid for or reimbursed under any government-sponsored program or by any government agency, foundation, health care facility, or health care provider, except as an otherwise qualifying full-time employee or dependent of such an employee of a government agency, foundation, health care facility, or health care provider;

(3) The board or the plan administrator shall require verification of residency and may require any additional information, documentation, or statements under oath whenever necessary to determine plan eligibility or residency;

(4) Coverage shall cease:

(A) On the date a person is no longer a resident of the State of Arkansas;

(B) On the date a person requests coverage to end;

(C) On the death of the covered person;

(D) On the date state law requires cancellation of the policy; or

(E) At the plan's option, thirty (30) days after the plan makes any written inquiry concerning a person's eligibility or place of residence to which the person does not reply; and

(5) Except under the conditions set forth in subdivision (a)(4) of this section, the coverage of any person who ceases to meet the eligibility requirements of this section shall be terminated at the end of the current policy period for which the necessary premiums have been paid.

(b) ~~Federally Eligible Individual~~ Persons eligible for guaranteed issuance of coverage. The following requirements apply to a federally

eligible individual or a qualified trade adjustment assistance eligible person in order for such individual to be eligible for plan coverage:

(1) Notwithstanding the requirements of subsection (a) of this section, any federally eligible individual or a qualified trade adjustment assistance eligible person for whom a plan application, and such enclosures and supporting documentation as the board may require, is received by the board within sixty-three (63) days after the termination of prior creditable coverage for reasons other than nonpayment of premium or fraud that covered the applicant shall qualify to enroll in the plan under the portability provisions of this subsection;

(2) Any ~~federally eligible~~ individual seeking plan coverage under this subsection must submit with his or her application evidence, including acceptable written certification of previous creditable coverage, that will establish to the board's satisfaction that he or she meets all of the requirements to be a federally eligible individual or a qualified trade adjustment assistance eligible person and is currently and permanently residing in the State of Arkansas as of the date his or her application was received by the board;

(3) A period of creditable coverage shall not be counted, with respect to qualifying an applicant for plan coverage as a ~~federally eligible~~ individual under this subsection, if after such period and before the application for plan coverage was received by the board, there was at least a sixty-three-day period during all of which the individual was not covered under any creditable coverage;

(4) Any ~~federally eligible~~ individual who the board determines qualifies for plan coverage under this subsection shall be offered his or her choice of enrolling in one of the alternative portability plans which the board is authorized under this subsection to establish for ~~these federally eligible~~ such individuals;

(5)(A) The board shall offer a choice of health-care coverages consistent with major medical coverage under the alternative plans authorized by this subsection to every ~~federally eligible~~ individual qualifying for coverage under this subsection. The coverages to be offered under the plans, the schedule of benefits, deductibles, copayments, coinsurance, exclusions, and other limitations shall be approved by the board.

(B) One (1) optional form of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in the State of Arkansas or a standard option of coverage available under the individual health insurance laws of the State of Arkansas. The standard plan that is authorized by § 23-79-510 may be used for this purpose.

(C) The board may also offer a preferred provider option and such other options as the board determines may be appropriate for ~~these federally eligible~~ individuals who qualify for plan coverage pursuant to this subsection;

(6) Notwithstanding the requirements of § 23-79-510(f), any plan coverage that is issued to ~~federally eligible~~ individuals who qualify for plan coverage pursuant to the portability provisions of this subsection shall not be subject to any preexisting conditions exclusion, waiting period, or other similar limitation on coverage;

(7) ~~Federally eligible individuals~~ Individuals who qualify and enroll in the plan pursuant to this subsection shall be required to pay such premium rates as the board shall establish and approve in accordance with the

requirements of § 23-79-507(a); ~~and~~

(8) The total premium, without regard to any subsidy of premium, for individuals who qualify and enroll in the plan pursuant to this subsection shall not be greater than a similarly situated individual qualifying for pool coverage under subsection (a) of this section; and

~~(8)~~(9) A federally eligible individual who qualifies and enrolls in the plan pursuant to this subsection must continue to satisfy all of the other eligibility requirements of this subchapter to the extent not inconsistent with the federal Health Insurance Portability and Accountability Act of 1996 in order to maintain continued eligibility for coverage under the plan.

(c) Any person who was issued a policy pursuant to the provisions of Act 1339 of 1995 shall be deemed continuously covered consistent with the terms of this subchapter and reissued a new policy in accordance with the provisions of this subchapter.

SECTION 5. Arkansas Code § 23-79-510(f), relating to pre-existing conditions, is amended to read as follows:

(f) Preexisting Conditions.

(1) Except for federally eligible individuals or qualified trade adjustment assistance eligible persons qualifying for plan coverage under § 23-79-509(b) or resident eligible persons or trade adjustment assistance eligible persons who qualify for and elect to purchase the waiver authorized in subdivision (f)(2) of this section, plan coverage shall exclude charges or expenses incurred during the first six (6) months following the effective date of coverage as to any condition if:

(A) The condition has manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinary prudent person to seek diagnosis, care, or treatment; or

(B) Medical advice, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of the coverage.

(2) Waiver. The preexisting condition exclusions as set forth in subdivision (f)(1) of this section will be waived to the extent to which the resident eligible person or trade adjustment assistance eligible person:

(A) Has satisfied similar exclusions under any prior individual health insurance coverage ~~or group health plan~~ that was involuntarily terminated;

~~(B) Is ineligible for any continuation coverage that would continue or provide substantially similar coverage following that termination;~~ and

~~(C)~~(B) Has applied for plan coverage not later than thirty (30) days following the involuntary termination. For each resident eligible person or trade adjustment assistance eligible person who qualifies for and elects this waiver, there shall be added to each payment of premium, on a prorated basis, a surcharge of up to ten percent (10%) of the otherwise applicable annual premium for as long as that individual's coverage under the plan remains in effect or sixty (60) months, whichever is less.

(3)(A) Whenever benefits are due from the plan because of sickness or an injury to a covered person resulting from a third party's wrongful act or negligence and the covered person has recovered or may

recover damages from a third party or its insurance carrier or self-insured entity, the plan shall have the right to reduce benefits or to refuse to pay benefits that otherwise may be payable in the amount of damages that the covered person has recovered or may recover regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury.

(B)(i) During the pendency of any action or claim that is brought by or on behalf of a covered person against a third party or its insurance carrier or self-insured entity, any benefits that would otherwise be payable except for the provisions of this subsection shall be paid if payment by or for the third party has not yet been made and the covered person or, if capable, that person's legal representative agrees in writing to pay back properly the benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the third party for the sickness or injury.

(ii) This agreement is to apply whether or not liability for the payments is established or admitted by the third party or whether those payments are itemized.

(C) Any amounts due the plan to repay benefits may be deducted from other benefits payable by the plan after payments by or for the third party are made.

(4) Benefits due from the plan may be reduced or refused as an offset against any amount otherwise recoverable under this section.

SECTION 6. <u>The Senate and House Interim Committees on Insurance and Commerce shall conduct a study of the Arkansas Comprehensive Insurance Pool for the purpose of determining a permanent, dedicated funding source for the deficits incurred by the Arkansas Comprehensive Insurance Pool.</u>"

The Amendment was read _____

By: Representative Napper

LDH/JMB - 032820030748

JMB510

_____

Chief Clerk