

As Engrossed: 4/7/95

1 **State of Arkansas**
2 **80th General Assembly**
3 **Regular Session, 1995**
4 **By: Representative Young**
5 ***By: Senators Boozman, Hunter, Dowd, Wilson, and Canada***

A Bill

ACT 1339 OF 1995
HOUSE BILL 2009

For An Act To Be Entitled

9 "AN ACT TO PROVIDE INSURANCE FOR INDIVIDUALS WITH HIGH-
10 RISK HEALTH CONDITIONS; AND FOR OTHER PURPOSES."

Subtitle

13 "COMPREHENSIVE HEALTH INSURANCE POOL
14 ACT."

16 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

18 SECTION 1. This act may be cited as the Comprehensive Health Insurance
19 Pool Act.

21 SECTION 2. For the purposes of this act the following definitions
22 apply:

23 (A) "Agent" means any person who is licensed to sell health insurance
24 in this state.

25 (B) "Board" means the Board of Directors of the State Comprehensive
26 Health Insurance Pool.

27 (C) "Health insurance" means any hospital or medical expense incurred
28 policy or nonprofit health care services plan contract, whether sold as an
29 individual or group policy. The term does not include any policy covering
30 short-term accident only, a fixed-indemnity policy, a limited benefit policy,
31 medical payment or personal injury coverage in a motor vehicle policy,
32 coverage issued as a supplement to liability insurance, a disability policy,
33 or workers_ compensation.

34 (D) "Insurer" means any individual, corporation, association,
35 partnership, fraternal benefit society, or any other entity engaged in the
36 health insurance business, except insurance agents and brokers. This term

1 shall also include medical services plans, hospital plans, health maintenance
2 organization and self-insurance arrangements, which shall be designated as
3 engaged in the business of insurance for the purposes of this act.

4 (E) "Medicare" means coverage under both Parts A and B of Title XVIII
5 of the Social Security Act (Public Law 74-271, 42 USC, Section 1395, et seq.,
6 as amended).

7 (F) "Pool" means the State Comprehensive Health Insurance Pool.

8 (G) "Physician" means a physician, osteopath, podiatrist, or, for
9 purposes of oral surgery only, a dental surgeon, each duly licensed by this
10 state.

11 (H) "Plan" means the Comprehensive Health Insurance Plan as adopted by
12 the Board of Directors of the State Comprehensive Health Insurance Pool, or by
13 rule.

14

15 SECTION 3. (A) Every insurer shall participate in the pool.

16 (B) Health insurance policies available in accordance with this act
17 shall be available for sale one year from the date of enactment of this act.

18

19 SECTION 4. (A) Except as provided in Subsection (B) of this section,
20 any *legal resident of this state for at least twelve (12) consecutive months*
21 *prior to application* shall be eligible for coverage under the plan, including:

22 (1) the insured_s spouse;

23 (2) any dependent unmarried child of the insured, from the moment
24 of birth. Such coverage shall terminate at the end of the premium period in
25 which the child marries, ceases to be a dependent of the insured, or attains
26 the age of 19, whichever occurs first. However, if the dependent is a full-
27 time student at an accredited institution of higher learning, the coverage may
28 continue while the child remains unmarried and a full-time student, but not
29 beyond the premium period in which the child reaches the age of 23.

30 (B) (1) No person who is currently receiving health care benefits under
31 any federal or state program providing financial assistance and/or preventive
32 and rehabilitative social services is eligible under the plan.

33 (2) No person who is covered under the plan and who terminates
34 coverage is again eligible for coverage unless twelve (12) months have elapsed
35 since the coverage was terminated.

1 (3) No person on whose behalf the plan has paid out five hundred
2 thousand dollars (\$500,000) or more in covered benefits is eligible for
3 coverage under the plan.

4 (4) The coverage of any person who ceases to meet the eligibility
5 requirements of this section may be terminated at the end of the policy
6 period.

7 (5) No person is eligible for coverage under the plan unless such
8 person has been rejected by at least two (2) insurers for coverage
9 substantially similar to the plan coverage without material underwriting
10 restriction at a rate equal to or less than the pool plan rate, and no person
11 is eligible for coverage who has on the date of issue of coverage under the
12 plan, equivalent coverage under another contract or policy.

13 (6) No inmate incarcerated in any state penal institution or
14 confined to any narcotic detention, treatment, and rehabilitation facility
15 shall be eligible for coverage under the plan.

16

17 SECTION 5. (A) There is hereby created a nonprofit legal entity to be
18 known as the "State Comprehensive Health Insurance Pool." All insurers, as a
19 condition of doing business in this state, shall be members of the pool.

20 (B) (1) The pool shall operate under the supervision and approval of a
21 seven member board of Directors appointed by the Commissioner of Insurance and
22 shall consist of:

23 (a) two (2) representatives of domestic insurance companies
24 licensed to do business in this state;

25 (b) one (1) representative of a nonprofit health care
26 service plan;

27 (c) one (1) representative of a health maintenance
28 organization;

29 (d) one (1) member from a health-related profession;

30 (e) one (1) member from the general public, who is not
31 associated with the medical profession, a hospital, or an insurer; and

32 (f) one (1) member to represent a group considered to
33 be "uninsurable."

34 (2) In making appointments to the Board of Directors, the
35 Commissioner shall strive to ensure that at least one person serving on the

1 Board of Directors is at least sixty (60) years of age.

2 (3) The original Board of Directors shall be appointed for the
3 following terms:

4 (a) three (3) members for a term of one (1) year;

5 (b) two (2) members for a term of two (2) years; and

6 (c) two (2) members for a term of (3) three years.

7 (4) All terms after the initial term shall be for three (3) years.

8 (5) The Board of Directors shall elect one of its members as
9 Chairman.

10 (6) Members of the Board of Directors may be reimbursed from monies
11 of the pool for actual and necessary expenses incurred by them in the
12 performance of their official duties as members of the Board of Directors, but
13 shall not otherwise be compensated for their services.

14 (7) The Board shall adopt a plan pursuant to this act and submit
15 its articles, bylaws, and operating rules to the State Commissioner of
16 Insurance for approval. If the Board fails to adopt such a plan and suitable
17 articles, bylaws, and operating rules within one hundred eighty (180) days
18 after the appointment of the Board, the State Commissioner of Insurance shall
19 promulgate rules to effectuate the provisions of this act; and such rules
20 shall remain in effect until superseded by a plan and articles, bylaws, and
21 operating procedures submitted by the Board and approved by the State
22 Commissioner of Insurance.

23

24 SECTION 6. The Board shall:

25 (A) establish administrative and accounting procedures for the operation
26 of the pool;

27 (B) establish procedures under which applicants and participants in the
28 plan may have grievances reviewed by an impartial body and reported to the
29 Board;

30 (C) select an administering insurer in accordance with Section 8 of this
31 act;

32 (D) (1) collect assessments from all insurers to provide for claims paid
33 under the plan and for administrative expenses incurred or estimated to be
34 incurred during the period for which assessment is made.

35 (2) the level of assessments.

1 (3) the insurer at the end of each calendar year. However, in
2 addition to such assessments, the Board shall collect an organizational
3 assessment or assessments from all insurers as necessary to provide for
4 expenses that have been incurred or are estimated to be incurred prior to the
5 receipt of the first calendar year assessments. Organizational assessments
6 shall be equal for all insurers, but shall not exceed one hundred dollars
7 (\$100) per insurer for all such assessments. Assessments shall be due and
8 payable within thirty (30) days of receipt of the assessment notice by the
9 insurer.

10 (E) require that all policy forms issued by the Board conform to
11 standard forms developed by the Board. The forms shall be approved by the
12 State Commissioner of Insurance.

13 (F) develop a program to publicize the existence of the plan, the
14 eligibility requirements of the plan, and the procedures for enrollment in the
15 plan, and to maintain public awareness of the plan.

16

17 SECTION 7. The Board shall:

18 (A) exercise powers granted to insurers under the laws of this state;

19 (B) sue or be sued;

20 (C) in addition to imposing assessments under Section 6 of this act,
21 levy interim assessments against insurers to insure the financial ability of
22 the plan to cover claims expenses and administrative expenses incurred or
23 estimated to be incurred in the operation of the plan prior to the end of the
24 calendar year. Any interim assessment shall be due and payable within thirty
25 (30) days of the receipt of the assessment notice by the insurer. Interim
26 assessments shall be credited against the insurer's annual assessment.

27

28 SECTION 8.(A) The Board shall select an insurer, through a competitive
29 bidding process, to administer the plan. The Board shall evaluate the bids
30 submitted under this subsection based on criteria established by the Board,
31 which criteria shall include, but not be limited to, the following:

32 (1) the insurer's proven ability to handle large group accident and
33 health policies insurance;

34 (2) the efficiency of the insurer's claims-paying procedures;

35 (3) an estimate of total charges for administering the plan.

1 (B) The administering insurer shall serve for a period of three (3)
2 years. At least one (1) year prior to the expiration of each three-year
3 period of service by an administering insurer, the Board shall invite all
4 insurers, including the current administering insurer, to submit bids to serve
5 as the administering insurer for the succeeding three-year period. The
6 selection of the administering insurer for the succeeding three-year period
7 shall be made at least six (6) months prior to the end of the current
8 three-year period.

9 (C) The administering insurer shall:

10 (1) perform all eligibility and administrative claims-payment
11 functions relating to the plan;

12 (2) pay an agent's referral fee as established by the Board to each
13 agent who refers an applicant to the plan, if the applicant is accepted. The
14 selling or marketing of plans shall not be limited to the administering
15 insurer or its agents. The referral fees shall be paid by the administering
16 insurer from moneys received as premiums for the plan;

17 (3) establish a premium billing procedure for collection of
18 premiums from persons insured under the plan;

19 (4) perform all necessary functions to assure timely payment of
20 benefits to covered persons under the plan, including, but not limited to, the
21 following:

22 (a) making available information relating to the proper manner
23 of submitting a claim for benefits under the plan and distributing forms upon
24 which submissions shall be made;

25 (b) evaluating the eligibility of each claim for payment under
26 the plan;

27 (c) notifying each claimant within thirty (30) days after
28 receiving a properly completed and executed proof of loss, whether the claim
29 is accepted, rejected, or compromised.

30 (5) submit regular reports to the Board regarding the operation of
31 the plan. The frequency, content, and form of the reports shall be determined
32 by the Board.

33 (6) following the close of each calendar year, determine net
34 premiums, re-insurance premiums less administrative expenses allowance, the
35 expense of administration pertaining to the re-insurance operations of the

1 pool, and the incurred losses for the year, and report this information to the
2 Board and to the Commissioner of Insurance.

3 (7) (a) Pay claims expenses from the premium payments received from,
4 or on behalf of, covered persons under the plan.

5 (b) If the payments by the administering insurer for claims
6 expenses exceeds the portion of premiums allocated by the Board for the
7 payment of claims expenses, the Board shall assess the additional funds
8 necessary for payment of claims expenses.

9

10 SECTION 9. (A) Each insurer shall be assessed by the Board a portion of
11 the operating losses of the plan; such portion being determined by multiplying
12 such operating losses by a fraction, the numerator of which equals the
13 insurer's premium and subscriber contract charges pertaining to the direct
14 writing of health insurance written in this state during the preceding
15 calendar year and the denominator of which equals the total of all such
16 premiums and subscriber contract charges written by participating insurers in
17 this state during the previous calendar year. The computation of assessments
18 shall be made with a reasonable degree of accuracy, with the recognition that
19 exact determinations may not always be possible.

20 (B) (1) If assessments and other receipts by the pool exceed the actual
21 losses and administrative expenses of the plan, the excess shall be held at
22 interest and used by the Board to offset future losses or to reduce premiums.

23 (2) As used in the Subsection, the term "future losses" includes
24 reserves for claims incurred but not reported.

25 (C) (1) Each insurer's proportion of participation in the plan shall be
26 determined annually by the Board based on annual statements and other reports
27 deemed necessary by the Board and filed with it by the insurer.

28 (2) Any deficit incurred under the plan shall be recouped by
29 assessment apportioned among participating insurers by the Board in the manner
30 set forth in Subsection (A) of this section; and the insurers may recover the
31 net loss, if any, after the tax offset provided in Section 10 of this act in
32 the normal course of their respective businesses without time limitation.

33

34 SECTION 10. (A) Any assessment may be offset, in an amount equal to the
35 amount of the assessment paid to the pool, against the state corporate income

1 tax or the premium tax payable by that participating insurer for the year in
2 which the assessment is levied or the four years subsequent to that year.

3 (B) (1) The Board may abate or defer, in whole or in part, the assessment
4 of a participating insurer if, in the opinion of the Board, payment of the
5 assessment would endanger the ability of the insurer to fulfill its
6 contractual obligations.

7 (2) In the event that an assessment against a participating insurer
8 is abated or deferred, in whole or in part, the amount by which such
9 assessment is abated or deferred may be assessed against the other
10 participating insurers in a manner consistent with the basis for assessment
11 set forth in Subsection (A) of Section 9 of this act, and the insurer
12 receiving the abatement or deferment shall remain liable to the pool for the
13 deficiency for four (4) years.

14 (C) Notwithstanding any provisions of this act to the contrary, no
15 participating insurer may be assessed in any one calendar year an amount
16 greater than the amount which that insurer paid to the state in the previous
17 year as premium tax and corporate income tax on the business to which this tax
18 applies, or one-hundredth of one percent (0.001%) of the total written
19 premiums on such business in this state, whichever is greater.

20

21 SECTION 11. The coverage provided by the plan shall be directly insured
22 by the pool, and the policies administered through the administering insurer.

23

24 SECTION 12. (A) (1) The plan shall offer in an annually renewable policy
25 the coverage specified in this section for each eligible person, except that
26 if an eligible person is also eligible for Medicare coverage, the plan shall
27 not pay or reimburse any person for expenses paid by Medicare.

28 (2) Any person whose health insurance is involuntarily terminated
29 for any reason other than nonpayment of premium may apply for coverage under
30 the plan. If such coverage is applied for within sixty (60) days after the
31 involuntary termination and if premiums are paid for the entire period of
32 coverage, the effective date of the coverage shall be the date of the
33 termination of the previous coverage.

34 (3) The plan shall provide that, upon the death or divorce of the
35 individual in whose name the contract was issued, every other person covered

1 in the contract may elect within sixty (60) days to continue under the same or
2 different contract.

3 (4) No coverage provided to a person who is eligible for Medicaid
4 benefits shall be issued as a Medicaid supplement policy.

5 (B)(1) The plan shall offer major medical expense coverage to every
6 eligible person who is not eligible for Medicare. Major medical expense
7 coverage offered under the plan shall pay an eligible person's covered
8 expenses, subject to the limits on the deductible and coinsurance payments
9 authorized under Subsection (E) of this section up to a lifetime limit of five
10 hundred thousand dollars (\$500,000) per covered individual. The maximum limit
11 under this paragraph shall not be altered by the Board, and no actuarially
12 equivalent benefit may be substituted by the Board.

13 (2) The plan shall provide that any policy issued to a person
14 eligible for Medicare shall be separately rated to reflect differences in
15 experiences reasonably expected to occur as a result of Medicare payments.

16 (C)(1) The usual customary charges for the following services and
17 articles, when prescribed by a physician, shall be covered expenses:

18 (a) hospital services;

19 (b) professional services for the diagnosis or treatment of
20 injuries, illness, or conditions, other than dental, which are rendered by a
21 physician or by others at his direction;

22 (c) drugs requiring a physician's prescription;

23 (d) services of a licensed skilled nursing facility for
24 eligible individuals, ineligible for Medicare, for not more than one hundred
25 eighty (180) calendar days during a policy year, if the services are the type
26 which would qualify as reimbursable services under Medicare;

27 (e) services of a home health agency, of which the services
28 are of a type which would qualify reimbursable services under Medicare;

29 (f) use of radium or other radioactive materials;

30 (g) oxygen;

31 (h) anesthetics;

32 (i) prosthesis, other than dental prosthesis;

33 (j) rental or purchase, as appropriate, of durable medical
34 equipment, other than eyeglasses and hearing aids;

35 (k) diagnostic x-rays and laboratory tests;

1 (1) oral surgery for partially or completely erupted, impacted
2 teeth and oral surgery with respect to the tissues of the mouth when not
3 performed in connection with the extraction or repair of teeth;

4 (m) services of a physical therapist;

5 (n) transportation provided by a licensed ambulance service to
6 the nearest facility qualified to treat the condition;

7 (o) processing of blood, including, but not limited to,
8 collecting, testing, fractioning, and distributing blood; and

9 (p) services for the treatment of alcohol and drug abuse, but
10 the insured shall be required to make a 50 percent (50%) co-payment and the
11 payment of the plan shall not exceed four thousand dollars (\$4,000).

12 (2) as an option, the plan shall make available, at an additional
13 premium, coverage for services provided by a duly licensed chiropractor.

14 (D) Covered expenses shall not include the following:

15 (1) any charge for treatment for cosmetic purposes, other than for
16 repair or treatment of any injury or congenital bodily defect to restore
17 normal bodily functions;

18 (2) any charge for care which is primarily for custodial or
19 domiciliary purposes which do not qualify as eligible services under Medicaid;

20 (3) any charge for confinement in a private room to the extent that
21 such charge is in excess of the charge by the institution for its most common
22 semiprivate room, unless a private room is prescribed as medically necessary
23 by a physician;

24 (4) that part of any charge for services or articles rendered or
25 provided by a physical or other health care personnel which exceeds the
26 prevailing charge in the locality where the service is provided, or any charge
27 for services or articles not medically necessary;

28 (5) any charge for services or articles the provision of which is
29 not within the authorized scope of practice of the institution or individual
30 providing the services or articles;

31 (6) any expense incurred prior to the effective date of the
32 coverage under the plan for the person on whose behalf the expense was
33 incurred;

34 (7) any charge for routing physical examinations;

35 (8) any charge for the services of blood donors and any fee for the

1 failure to replace the first three (3) pints of blood as provided to an
2 eligible person annually; or
3 (9) any charge for personal services or supplies provided by a
4 hospital or nursing home, or any other nonmedical or nonprescribed services or
5 supplies.

6 (E)(1) The plan shall provide for a choice of annual deductibles for
7 major medical expenses in the amount of one thousand dollars (\$1,000), five
8 thousand dollars (\$5,000), and ten thousand dollars (\$10,000), plus the
9 benefits payable under any other type of insurance coverage or worker's
10 compensation, provided that if two individual members of a family satisfy the
11 applicable deductible, no other members of the family shall be required to
12 meet deductibles for the remainder of that calendar year.

13 (2) the schedule of premiums and deductibles shall be established
14 by the Board.

15 (3) rates for coverage issued by the pool may not be unreasonable
16 in relation to the benefits provided, the risk experience, and the reasonable
17 expenses of providing coverage.

18 (4) Separate schedules of premium rates based on age may apply for
19 individual risks.

20 (5) Rates are subject to approval by the Commissioner of Insurance.
21

22 SECTION 13. All provisions of this act of a general and permanent
23 nature are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas
24 Code Revision Commission shall incorporate the same in the Code.
25

26 SECTION 14. If any provision of this act or the application thereof to
27 any person or circumstance is held invalid, such invalidity shall not affect
28 other provisions or applications of the act which can be given effect without
29 the invalid provision or application, and to this end the provisions of this
30 act are declared to be severable.
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32 SECTION 15. All laws and parts of laws in conflict with this act are
33 hereby repealed.
34

35 /s/Rep. Young, et al

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APPROVED: 4-17-95