Stricken language would be deleted from present law. Underlined language would be added to present law.

State of Arkansas *As Engrossed: H1/29/97 H2/6/97*
81st General Assembly **A Bill** ACT 292 OF 1997
Regular Session, 1997 HOUSE BILL 1369

By: Representative Young

For An Act To Be Entitled

"AN ACT TO AMEND THE ARKANSAS INSURANCE CODE TO ESTABLISH THE COMPREHENSIVE HEALTH INSURANCE POOL, TO REPEAL ARKANSAS CODE ANNOTATED § 23-79-501 TO 510; AND FOR OTHER PURPOSES."

Subtitle

"ACT TO CREATE COMPREHENSIVE HEALTH INSURANCE POOL."

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

SECTION 1. Short Title.

This Act may be cited as the "Comprehensive Health Insurance Pool Act," and is amendatory to the Arkansas Insurance Code, Arkansas Code Annotated § 23-60-101, et seq. and the provisions of the Arkansas Insurance Code which are not in conflict with this Act are applicable to this Act.

SECTION 2. Purpose.

(a) *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 act 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 Act.

(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 Section 9(b) of this Act, but does not intend for every eligible person who qualifies for pool coverage in accordance with Section 9 of this Act to be guaranteed a right to be issued a policy under this pool as a matter of entitlement.

SECTION 3. Definitions.

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

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

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

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

(d) "Commissioner" means the Insurance Commissioner for the state of Arkansas;

(e) "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, Section 23-86-114 of the Arkansas Insurance Code, or any other similar requirement in another state;

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

(g)(1) "Creditable coverage" means, with respect to a federally eligible individual, coverage of the individual under any of the following:

(A) A group health plan;

(B) Health insurance coverage (including group health insurance coverage);

(C) Medicare;

(D) Medical assistance;

(E) Chapter 55 of Title 10, United States Code;

(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;

(I) 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 U.S. Department of Health and Human Services);

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

(2) Creditable coverage does not include 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) nor does it include any period of coverage under any of items (A) through (J) of Subsection 3(g)(1) that occurred before a break of more than sixty-three (63) days during all of which the individual was not covered under any of items (A) through (J) of Subsection 3(g)(1). 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;

(h) "Department" means Arkansas Insurance Department;

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

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

(1) (A) for whom, as of the date on which the individual seeks pool coverage under Section 9 of this Act, the aggregate of the periods of creditable coverage is eighteen (18) or more months; and

(B) 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); and

(2) who is not eligible for coverage under:

(A) a group health plan;

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

(C) medical assistance, and does not have other health insurance coverage; and

(3) with respect to whom the most recent coverage within the coverage period described in paragraph (1)(A) of this definition was not terminated based upon a factor related to nonpayment of premiums or fraud; and

(4) if the individual has been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

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

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

(m) "Health insurance" means any hospital and medical expense incurred policy, certificate, or contract, provided by an insurer, hospital 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. The term does not include 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;

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

(o) "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 Act, 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;

(p) "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;

(q) "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. A service, drug, supply or article shall not be medically necessary if it: (i) is investigational, experimental, or for research purposes; or (ii) is provided solely for the convenience of the patient, the patient's family, physician, hospital, or any other provider; or (iii) exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; or (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;

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

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

(t) "Plan" means the comprehensive health insurance plan as adopted by the board of the Arkansas Comprehensive Health Insurance Pool or by rule;

(u) "Plan Administrator" means the insurer designated under Section 8 of this Act to carry out the provisions of the plan of operation;

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

(w) "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* supplies;

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

(y) "Resident eligible person" means a person who has been legally domiciled in the state of Arkansas for a period of at least thirty (30) days and continues to be domiciled in Arkansas.

SECTION 4. Arkansas Comprehensive Health Insurance Pool.

(a) There is hereby created a nonprofit legal entity to be known as the *"Arkansas Comprehensive Health Insurance Pool" as the successor entity to the non-profit legal entity established by Act 1339 of 1995.*

(b)(1) The pool shall operate subject to the supervision and control of the board. The pool is created as a political subdivision, instrumentality and body politic of the state of Arkansas, and, as such, is not a state agency. The pool will be exempt from all state, county and local taxes, A.C.A. § 9-11-201, et seq., A.C.A. § 25-19-101, et seq. and A.C.A. § 25-15-201, et seq., except to the extent defined in this Act. The board shall consist of 7 members to be appointed by the Commissioner which shall consist of:

(A) Two (2) representatives of domestic insurance companies licensed to do business in the state of Arkansas;

(B) Two (2) representatives of health maintenance organizations licensed to do business in the state of Arkansas;

(C) One (1) member of a health-related profession licensed in the state of Arkansas;

(D) One (1) member from the general public, who is not associated with the medical profession, a hospital, or an insurer; and

(E) One (1) member to represent a group considered to be "uninsurable".

(2) In making appointments to the board, the Commissioner shall strive to ensure that at least one (1) person serving on the board is at least sixty (60) years of age.

(3) All terms shall be for three (3) years.

(4) The board shall elect one (1) of its members as Chairman.

(5) Any vacancy in the Board occurring for any reason other than the expiration of a term shall be filled for the unexpired term in the same manner as the original appointment.

(6) Members of the board may be reimbursed from monies of the pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the board, but shall not otherwise be

compensated for their services.

(c) All insurers, as a condition of doing business in the state of Arkansas, shall participate in the pool by paying the assessments, submitting the reports and providing the information required by the board or the Commissioner to implement the provisions of this Act.

(d) Neither the board nor its employees shall be liable for any obligations of the pool. No board member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this Act. The board may provide in its bylaws or rules for indemnification of, and legal representation for, the board members and employees.

SECTION 5. Plan of Operation.

(a) The board shall adopt a plan of operation pursuant to this Act and shall submit to the Commissioner for approval such plan of operation including the *pool's* articles, bylaws and operating rules and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The plan of operation shall become effective upon approval in writing by the Commissioner. If the board fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the Commissioner shall adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of this Section. Such rules shall continue in force until modified by the Commissioner or superseded by a plan of operation submitted by the board and approved by the Commissioner.

(b) The plan of operation shall:

(1) Establish procedures for operation of the pool;

(2) Establish procedures for selecting a plan administrator in accordance with Section 8 of this Act;

(3) Create a fund, under management of the board, to pay administrative, claims and other expenses of the pool;

(4) Establish procedures for the handling, accounting and auditing of assets, monies and claims of the pool and the plan administrator;

(5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to

maintain public awareness of the plan;

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board after completion of the review. The board shall retain all written complaints regarding the plan for at least three (3) years;

(7) Provide for other matters as may be necessary and proper for the execution of the board's powers, duties and obligations under this Act.

SECTION 6. Powers.

(a) The pool shall have the general powers and authority granted under the laws of the state of Arkansas to health insurers and in addition thereto, the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act;

(2) Sue or be sued, including taking any legal actions necessary or proper;

(3) Take such legal action as necessary, including but not limited to:

(A) To avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(B) To recover any amounts erroneously or improperly paid by the pool;

(C) To recover any amounts paid by the pool as a result of mistake of fact or law;

(D) To recover other amounts due the pool; or

(E) To coordinate legal action with the Commissioner to enforce the provisions of this Act.

(4) Establish and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas, deductibles, copayments, coinsurance, and any other actuarial function appropriate to the operation of the pool. Rates and rate schedules may be adjusted for appropriate factors such as age, sex and geographical variation in claim costs and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

(5) Issue policies of insurance in accordance with the requirements of this Act. All policy forms shall be subject to the approval of the Commissioner;

(6) Authorize the plan administrator to prepare and distribute certificate of eligibility forms and enrollment instruction forms to agents and to the general public;

(7) Provide for and employ cost containment measures and requirements including, but not limited to, pre-admission screening, second surgical opinion, concurrent utilization review, and individual case management for the purposes of making the plan more cost effective;

(8) Design, utilize, contract or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting directly or through the plan administrator with preferred provider organizations, health maintenance organizations, physician hospital organizations, or other limited network provider arrangements;

(9) Borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets;

(10) Pledge, assign and grant a security interest in any of the assessments authorized by this Act or other assets of the pool in order to secure any notes or other evidences of indebtedness of the pool;

(11) Provide for reinsurance of risks incurred by the pool;

(12) Provide additional types of plans to provide optional coverages, including Medicare Supplement health insurance;

(13) In addition to the other powers granted by the Arkansas Insurance Code, the Commissioner may, after notice and hearing in accordance with the provisions of the Arkansas Insurance Code, impose a monetary penalty upon any insurer, or suspend or revoke the Certificate of Authority to transact insurance in the state of Arkansas of any insurer, who fails to pay an assessment or otherwise file any report or furnish information required to be filed with the board pursuant to the board's direction that the board believes is necessary in order for the board to perform its duties under this Act.

(b) All outstanding contracts executed by the board of directors of the State Comprehensive Health Insurance Pool created by Act 1339 of 1995, shall be deemed continuing obligations of the board created by this act.

SECTION 7. Funding of Pool.

(a) Premiums.

(1) The pool shall establish premium rates for plan coverage as provided in Subsection (2). 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 Commissioner for approval prior to use.

(2) 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 such coverage. Initial rates for plan coverage shall not be less than one hundred fifty percent (150%) of rates established as applicable for individual standard risks in Arkansas. Subject to the limits provided in this paragraph, 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 Section 6, 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 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 (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. The deficit incurred by the pool shall be recouped by assessments apportioned by the board among insurers.

(3) Each insurer's assessment shall be determined by multiplying the total assessment of all insurers as determined in paragraph (2) of this Subsection 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 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) 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, such assessment if, in the opinion of the Commissioner, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which such 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 such abatement or deferment shall remain liable to the plan for the deficiency for four (4) years.

(7) From the effective date of this Act 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 Act, 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 and 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 Section 3(o) of this Act shall be subject to assessment.

(c) Assessment Offsets

(1) 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 the four (4) years subsequent to that year.

(2) Notwithstanding any provisions of this act 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 such business in this state, whichever is greater.

(d) 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 (30) 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 Act and the Arkansas Insurance Code. The board may waive the penalty authorized by this Subsection if it determines that compelling circumstances exist which justify such waiver.

SECTION 8. Plan Administrator.

(a) The board shall select an insurer through a competitive bidding process to administer the *plan; provided however, that the administering insurer designated by the board created by Act 1339 of 1995 shall serve as the plan administrator under this act until the expiration of the current contract of the administering insurer.* The board shall evaluate bids submitted under this Section based upon criteria established by the board which shall include, but not be limited to, the following:

(1) The plan administrator's proven ability to handle large group accident and health benefit plans;

(2) The efficiency and timeliness of the plan administrator's claim processing procedures;

(3) An estimate of total charges for administering the plan;

(4) The plan administrator's ability to apply effective cost

containment programs and procedures and to administer the plan in a cost efficient manner;

(5) The financial condition and stability of the plan administrator.

(b) The plan administrator shall serve for a period of three (3) years subject to removal for cause and subject to the terms, conditions and limitations of the contract between the board and the plan administrator. The board shall advertise for and accept bids to serve as the plan administrator for the succeeding three (3) year periods.

(c) The plan administrator shall perform functions related to the plan as may be assigned to it including:

(1) Determination of eligibility;

(2) Payment and processing of claims;

(3) Establishment of a premium billing procedure for collection of premiums. Billings shall be made on a periodic basis as determined by the board;

(4) Other necessary functions to assure timely payment of benefits to covered persons under the plan, including:

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

(B) Evaluating the eligibility of each claim for payment under the plan.

(d) The plan administrator shall submit regular reports to the board regarding the operation of the plan. Frequency, content and form of the report shall be determined by the board.

(e) The plan administrator shall pay claim expenses from the premium payments received from or on behalf of plan participants and allocated by the board for claim expenses. If the plan administrator's payments for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide additional funds to the plan administrator for payment of claims expenses.

(f) The plan administrator shall be governed by the requirements of this Act and shall be compensated as provided in the contract between the board and the plan administrator.

SECTION 9. Plan Eligibility.

(a) Resident Eligible Person. The following requirements apply to a resident eligible person in order for such person to be eligible for plan coverage:

(1) Except as provided in Subsection (a)(2) or (b) of this Section, any individual person who is either a citizen of the United States or an alien lawfully admitted for permanent residence and who has been legally domiciled in the state of Arkansas for a period of at least thirty (30) days and continues to be domiciled in the state of Arkansas 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 deems sufficient in order to verify that the applicant is unable to obtain such coverage from an insurer due to the existence or history of a medical condition; or

(B) 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;

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;

(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 pre-existing condition waiting period under a plan policy; and

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

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

(C) 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;

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

(E) The person is a resident of a public institution;

(F) The person's premium is paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as a otherwise qualifying full time employee, or dependent of such employee, of a government agency 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 (i) on the date a person is no longer a resident of the state of Arkansas; (ii) on the date a person requests coverage to end; (iii) on the death of the covered person; (iv) on the date state law requires cancellation of the policy, or (v) 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;

(5) Except under the conditions set forth in Subsection (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. The following requirements apply to a federally eligible individual 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 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 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 (63) 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 individuals;

(5) 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. 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. One 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 Section 10 of this Act may be used for this purpose. 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 Subsection (f) of Section 10, 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 pre-existing conditions exclusion, waiting period, or other similar limitation on coverage;

(7) Federally eligible 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 Section 7(a) of this Act;

(8) 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 Act 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 Act and reissued a new policy in accordance with the provisions of this Act.

SECTION 10. Outline of Benefits.

(a)(1) Subject to the contractual policy form language adopted by the board, expenses for the following *services, supplies, drugs, or* articles when prescribed by a physician and determined by the plan to be medically necessary shall be covered, subject to provisions of Subsection (b):

(A) Hospital services;

(B) Professional services for the diagnosis or treatment of injuries, illnesses or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction;

(C) Drugs requiring a physician's prescription;

(D) Skilled nursing services of a licensed skilled nursing facility for not more than one hundred twenty (120) days during a policy year;

(E) Services of a home health agency up to a maximum of two hundred seventy (270) services per year;

(F) Use of radium or other radioactive materials;

(G) Oxygen;

(H) Prostheses other than dental;

(I) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which such equipment is prescribed;

(J) Diagnostic X-rays and laboratory tests;

(K) Oral surgery for excision of partially or completed

unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(L) Services of a physical therapist;

(M) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest facility qualified to treat a covered condition;

(N) Services for diagnosis and treatment of mental and nervous disorders or chemical and drug dependency provided that a covered person shall be required to make a fifty percent (50%) copayment, and that the plan's payment shall not exceed four thousand dollars ($4,000) annually;

(O) Such additional benefits deemed appropriate by the board in accordance with the provisions of Subsection (b).

(2) Exclusions. Subject to the contractual policy form language adopted by the board, the following services, supplies, drugs or articles whether prescribed by a physician or not shall not be covered:

(A) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;

(B) Care which is primarily for custodial or domiciliary purposes;

(C) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is medically necessary;

(D) That part of any charge for services rendered or articles prescribed by a physician, dentist or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary;

(E) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;

(F) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred;

(G) Dental care except as provided in *Subsection (a)(1)(K);*

(H) Eyeglasses and hearing aids;

(I) Illness or injury due to acts of war;

(J) Services of blood donors and any fee for failure to

replace the first three (3) pints of blood provided to a covered person each policy year;

(K) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service;

(L) Routine maternity charges for a pregnancy, except where added as optional coverage with payment of additional premiums;

(M) Any expense or charge for services, *articles,* drugs or supplies that are not provided in accord with generally accepted standards of current medical practice;

(N) Any expense or charge for routine physical examinations or tests;

(O) Any expense for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay;

(P) Any expense incurred for benefits provided under the laws of the United States and the state of Arkansas, including Medicare and Medicaid and other medical assistance, military service-connected disability payments, medical services provided for members of the armed forces and their dependents or employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States;

(Q) Any expense or charge for invitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy;

(R) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures;

(S) Any expense or charge for sterilization or sterilization reversals;

(T) Any expense or charge for weight loss programs, exercise equipment or treatment of obesity, except when certified by a physician as morbid obesity (at least two times normal body weight);

(U) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery;

(V) Any expense or charge for organ or bone marrow transplants other than those performed at a hospital with a board approved organ transplant program that has been designated by the board as a preferred provider organization for that specific organ or bone marrow transplant;

(W) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical specialty college for general use within the medical community;

(X) Such additional exclusions deemed appropriate by the board in accordance with the provisions of Subsection (b).

(b) In establishing the plan coverage, the board shall take into consideration the levels of health insurance provided in the state and medical economic factors as may be deemed appropriate; and promulgate benefits, deductibles, copayments, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.

(c) The board may adjust any deductibles, copayments and coinsurance factors annually according to the Medical Component of the Consumer Price Index.

(d) Nonduplication of Benefits.

(1) The pool shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance or any other source providing benefits because of a sickness or injury and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The pool shall have a cause of action against a covered person *for the recovery of the amount of benefits paid that are not covered by* the pool. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this paragraph.

(e) Right of Subrogation: Recoveries.

(1) Whenever the pool has paid benefits because of sickness or an injury to any covered person resulting from a third party's wrongful act or negligence, or for which an insurance company or self insured entity is liable

in accordance with the provisions of any policy of insurance, and the covered person has recovered or may recover damages from a third party that is liable for damages, the pool shall have the right to recover the benefits it paid from any amounts that the covered person has received or may receive regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from the sickness or injury. The pool shall be subrogated to any right of recovery the covered person may have under the terms of any private or public health care coverage or liability coverage, including coverage under a Workers' Compensation Act without the necessity of assignment of claim or other authorization to secure the right of recovery. To enforce its subrogation right, the pool may (i) intervene or join in an action or proceeding brought by the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, against any third party or the third party's insurance carrier or self insured entity that may be liable; or (ii) institute and prosecute legal proceedings against any third party or the third party's insurance carrier or self insured entity that may be liable for the sickness or injury in an appropriate court either in the name of the pool or in the name of the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors.

(2) If any action or claim is brought by or on behalf of a covered person against a third party or the third party's insurance carrier or self insured entity, the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, shall notify the pool by personal service or registered mail of the action or claim and of the name of the court in which the action or claim is brought, filing proof thereof in the action or claim. The pool may, at any time thereafter, join in the action or claim upon its motion so that all orders of court after hearing and judgment shall be made for its protection. No release or settlement of a claim for damages and no satisfaction of judgment in the action shall be valid without the written consent of the pool to the extent of its interest in the settlement or judgment and of the covered person or his personal representative.

(3) In the event that the covered person or his personal representative fails to institute a proceeding against any appropriate third party before the fifth month before the action would be barred, the pool may,

in its own name or in the name of the covered person or personal representative, commence a proceeding against any appropriate third party for the recovery of damages on account of any sickness, injury, or death to the covered person. The covered person shall cooperate in doing what is reasonably necessary to assist the pool in any recovery and shall not take any action that would prejudice the pool's right to recovery. The pool shall pay to the covered person or his personal representative all sums collected from any third party by judgment or otherwise in excess of amounts paid in benefits under the pool and amounts paid or to be paid as costs, attorneys fees, and reasonable expenses incurred by the pool in making the collection or enforcing the judgment.

(4) In the event of judgment or award in either a suit or claim against a third party, the court shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees. After payment of those expenses and attorney's fees, the court shall apply out of the balance of the judgment or award an amount sufficient to reimburse the pool the full amount of benefits paid on behalf of the covered person under this Act, provided the court may reduce and apportion the pool's portion of the judgment proportionate to the recovery of the covered person. The burden of producing sufficient evidence to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking the reduction. The court may consider the nature and extent of the injury, economic and non-economic loss, settlement offers, comparative or contributory negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The pool shall pay its prorata share of the attorney's fees based on the pool's recovery as it compares to the total judgment. Any reimbursement rights of the pool shall take priority over all other liens and charges existing under the laws of the state of Arkansas.

(5) The pool may compromise or settle and release any claim for benefits provided under this Act or waive any claims for benefits, in whole or in part, for the convenience of the pool or if the pool determines that collection will result in undue hardship upon the covered person.

(f) Pre-existing Conditions.

(1) Except for federally eligible individuals qualifying for plan

coverage under Section *9(b)* of this Act or resident eligible persons who qualify for and elect to purchase the waiver authorized in paragraph (2) of this Subsection, 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 (6) 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 (6) month period immediately preceding the effective date of the coverage.

(2) Waiver: The pre-existing condition exclusions as set forth in paragraph (1) of this Subsection will be waived to the extent to which the *resident* eligible person:

(A) Has satisfied similar exclusions under any prior 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) Has applied for plan coverage not later than thirty (30) days following the involuntary termination. For each resident eligible person who qualifies for and elects this waiver, there shall be added to each payment of premium, on a pro-rated 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) 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 10(f) 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. 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 11. Confidentiality.

(a) All steps necessary under state and federal law to protect confidentiality of applicants and covered persons shall be undertaken by the board to prevent the identification of individual records of covered persons under the plan, rejected by the plan, or who may become ineligible for further participation in the plan. Procedures shall be written by the board to assure the confidentiality records of persons covered under, rejected by, or who became ineligible for further participation *in the* plan when gathering and submitting data to the board or any other entity.

(b) Any information submitted to the board by hospitals or any other provider pursuant to this Act from which the *identity* of a particular individual can be determined shall be privileged and confidential, and shall not be disclosed in any manner. The foregoing includes, but shall not be limited to, disclosure, inspection or copying under A.C.A. § 25-19-101, et seq.

SECTION 12. Collective Action.

Neither the participation in the plan as insurers, the establishment of rates, forms or procedures nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil

liability or penalty against the plan or any insurer.

SECTION 13. Unfair Referral to Plan.

(a) Except as provided in Subsection (b), it shall constitute an unfair trade practice for the purposes of A.C.A. § 23-66-201, et seq., for an insurer, agent, broker or third-party administrator to refer an individual to the pool, or arrange for an individual to apply to the pool, for the purpose of separating that individual from group health insurance coverage provided in connection with any group health insurance coverage.

(b) The provisions of Subsection (a) shall not apply with respect to group health insurance coverage provided to groups with fewer than fifteen (15) members.

SECTION 14. All provisions of this act of a general and permanent nature are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas Code Revision Commission shall incorporate the same in the Code.

SECTION 15. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

SECTION 16. All laws and parts of laws in conflict with this act are hereby repealed.

SECTION 17. Arkansas Code 23-79-501 through 510 is repealed.

~~§ 23-79-501. Short Title.~~

~~This subchapter may be cited as the "Comprehensive Health Insurance Pool Act."~~

~~§ 23-79-502. 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 State Comprehensive~~

~~Health Insurance Pool;~~

~~(3)(A) "Health insurance" means any hospital or medical expense incurred policy or nonprofit health care services plan contract, whether sold as an individual or group policy.~~

~~(B) The term does not include:~~

~~(i) Any policy covering a short-term accident only;~~

~~(ii) A fixed-indemnity policy;~~

~~(iii) A limited benefit policy;~~

~~(iv) Medical payment or personal injury coverage in a motor vehicle policy;~~

~~(v) Coverage issued as a supplement to liability insurance;~~

~~(vi) A disability policy; or~~

~~(vii) Workers' compensation;~~

~~(4)(A) "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers.~~

~~(B) 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 subchapter;~~

~~(5) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act (P.L. 74-271, 42 U.S.C. § 1395 et seq., as amended);~~

~~(6) "Pool" means the State Comprehensive Health Insurance Pool;~~

~~(7) "Physician" means a physician, osteopath, podiatrist, or, for purposes of oral surgery only, a dental surgeon, each duly licensed by this state; and~~

~~(8) "Plan" means the comprehensive health insurance plan as adopted by the Board of Directors of the State Comprehensive Health Insurance Pool or by rule.~~

~~§ 23-79-503. State Comprehensive Health Insurance Pool.~~

~~(a)(1) There is hereby created a nonprofit legal entity to be known as the "State Comprehensive Health Insurance Pool".~~

~~(2)(A) All insurers, as a condition of doing business in this state, shall be members of the pool.~~

~~(B) Every insurer shall participate in the pool.~~

~~(b)(1) The pool shall operate under the supervision and approval of a seven-member board of directors appointed by the Insurance Commissioner and shall consist of:~~

~~(A) Two (2) representatives of domestic insurance companies licensed to do business in this state;~~

~~(B) One (1) representative of a nonprofit health care service plan;~~

~~(C) One (1) representative of a health maintenance organization;~~

~~(D) One (1) member from a health-related profession;~~

~~(E) One (1) member from the general public, who is not associated with the medical profession, a hospital, or an insurer; and~~

~~(F) One (1) member to represent a group considered to be "uninsurable."~~

~~(2) In making appointments to the board of directors, the Insurance Commissioner shall strive to ensure that at least one (1) person serving on the board of directors is at least sixty (60) years of age.~~

~~(3) All terms shall be for three (3) years.~~

~~(4) The board of directors shall elect one (1) of its members as chairman.~~

~~(5) Members of the board of directors may be reimbursed from moneys of the pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the board of directors, but shall not otherwise be compensated for their services.~~

~~(c)(1) The board shall adopt a plan pursuant to this subchapter and submit its articles, bylaws, and operating rules to the Insurance Commissioner for approval.~~

~~(2) If the board fails to adopt such a plan and suitable articles, bylaws, and operating rules within one hundred eighty (180) days after the appointment of the board, the Insurance Commissioner shall promulgate rules to effectuate the provisions of this subchapter, and such rules shall remain in effect until superseded by a plan and articles, bylaws, and operating procedures submitted by the board and approved by the Insurance Commissioner.~~

~~§ 23-79-504. Operation - Grievance procedures - Administering insurer - Collection - Forms - Publicity.~~

~~The board shall:~~

~~(1) Establish administrative and accounting procedures for the~~

~~operation of the pool;~~

~~(2) Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board;~~

~~(3) Select an administering insurer in accordance with § 23-79-506;~~

~~(4)(A) Collect assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made.~~

~~(B) The level of assessments.~~

~~(C) The insurer at the end of each calendar year. However, in addition to such assessments, the board shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses that have been incurred or are estimated to be incurred prior to the receipt of the first calendar year assessments. Organizational assessments shall be equal for all insurers, but shall not exceed one hundred dollars ($100) per insurer for all such assessments. Assessments shall be due and payable within thirty (30) days of receipt of the assessment notice by the insurer;~~

~~(5) Require that all policy forms issued by the board conform to standard forms developed by the board. The forms shall be approved by the Insurance Commissioner; and~~

~~(6) Develop a program to publicize the existence of the plan, the eligibility requirements of the plan, and the procedures for enrollment in the plan, and to maintain public awareness of the plan.~~

~~§ 23-79-505. Powers - Suits - Interim assessments.~~

~~The board shall:~~

~~(1) Exercise powers granted to insurers under the laws of this state;~~

~~(2) Sue or be sued;~~

~~(3)(A) In addition to imposing assessments under § 23-79-504, levy interim assessments against insurers to ensure the financial ability of the plan to cover claims expenses and administrative expenses incurred or estimated to be incurred in the operation of the plan prior to the end of the calendar year.~~

~~(B) Any interim assessment shall be due and payable within thirty (30) days of the receipt of the assessment notice by the insurer.~~

~~(C) Interim assessments shall be credited against the insurer's annual assessment.~~

~~§ 23-79-506. Selection of insurer.~~

~~(a)(1) The board shall select an insurer, through a competitive bidding process, to administer the plan.~~

~~(2) The board shall evaluate the bids submitted under this subsection based on criteria established by the board, which criteria shall include, but not be limited to, the following:~~

~~(A) The insurer's proven ability to handle large group accident and health policies insurance;~~

~~(B) The efficiency of the insurer's claims-paying procedures;~~

~~(C) An estimate of total charges for administering the plan.~~

~~(b)(1) The administering insurer shall serve for a period of three (3) years.~~

~~(2) At least one (1) year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period.~~

~~(3) The selection of the administering insurer for the succeeding three-year period shall be made at least six (6) months prior to the end of the current three-year period.~~

~~(c) The administering insurer shall:~~

~~(1) Perform all eligibility and administrative claims-payment functions relating to the plan;~~

~~(2)(A) Pay an agent's referral fee as established by the board to each agent who refers an applicant to the plan, if the applicant is accepted.~~

~~(B) The selling or marketing of plans shall not be limited to the administering insurer or its agents.~~

~~(C) The referral fees shall be paid by the administering insurer from moneys received as premiums for the plan;~~

~~(3) Establish a premium billing procedure for collection of premiums from persons insured under the plan;~~

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

~~(A) Making available information relating to the proper manner of submitting a claim for benefits under the plan, and distributing forms upon which submissions shall be made;~~

~~(B) Evaluating the eligibility of each claim for payment under the plan;~~

~~(C) Notifying each claimant within thirty (30) days after receiving a properly completed and executed proof of loss, whether the claim is accepted, rejected, or compromised;~~

~~(5)(A) Submit regular reports to the board regarding the operation of the plan.~~

~~(B) The frequency, content, and form of the reports shall be determined by the board;~~

~~(6)(A) Following the close of each calendar year, determine:~~

~~(i) Net premiums;~~

~~(ii) Reinsurance premiums, less administrative expenses allowance;~~

~~(iii) The expense of administration pertaining to the reinsurance operations of the pool; and~~

~~(iv) The incurred losses for the year; and~~

~~(B) Report this information to the board and to the Insurance Commissioner; and~~

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

~~(B) If the payments by the administering insurer for claims expenses exceed the portion of premiums allocated by the board for the payment of claims expenses, the board shall assess the additional funds necessary for payment of claims expenses.~~

~~§ 23-79-507. Computation of assessments.~~

~~(a)(1) Each insurer shall be assessed by the board a portion of the operating losses of the plan, such portion being determined by multiplying such operating losses by a fraction, the numerator of which equals the insurer's premium and subscriber contract charges pertaining to the direct writing of health insurance written in this state during the preceding calendar year, and the denominator of which equals the total of all such premiums and subscriber contract charges written by participating insurers in~~

~~this state during the previous calendar year.~~

~~(2) The computation of assessments shall be made with a reasonable degree of accuracy, with the recognition that exact determinations may not always be possible.~~

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

~~(2) As used in this subsection, the term "future losses" includes reserves for claims incurred but not reported.~~

~~(c)(1) Each insurer's proportion of participation in the plan shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed with it by the insurer.~~

~~(2) Any deficit incurred under the plan shall be recouped by assessment apportioned among participating insurers by the board in the manner set forth in subsection (a) of this section, and the insurers may recover the net loss, if any, after the tax offset provided in § 23-79-508 in the normal course of their respective businesses without time limitation.~~

~~§ 23-79-508. Offsets and amounts of assessments.~~

~~(a) Any assessment may be offset in an amount equal to the amount of the assessment paid to the pool against the state corporate income tax or the premium tax payable by that participating insurer for the year in which the assessment is levied, or the four (4) years subsequent to that year.~~

~~(b)(1) The board may abate or defer, in whole or in part, the assessment of a participating insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations.~~

~~(2) In the event that an assessment against a participating insurer is abated or deferred, in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other participating insurers in a manner consistent with the basis for assessment set forth in § 23-79-507(a), and the insurer receiving the abatement or deferment shall remain liable to the pool for the deficiency for four (4) years.~~

~~(c) Notwithstanding any provisions of this subchapter to the contrary, no participating 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 and corporate income tax on the business to which this tax applies, or one-hundredth of one percent (0.01%) of the total written premiums on such business in this state, whichever is greater.~~

~~§ 23-79-509. Eligibility for coverage.~~

~~(a) Except as provided in subsection (b) of this section, any legal resident of this state for at least twelve (12) consecutive months prior to application shall be eligible for coverage under the plan, including:~~

~~(1) The insured's spouse;~~

~~(2)(A) Any dependent unmarried child of the insured, from the moment of birth.~~

~~(B)(i) Such coverage shall terminate at the end of the premium period in which the child marries, ceases to be a dependent of the insured, or attains the age of nineteen (19), whichever occurs first.~~

~~(ii) However, if the dependent is a full-time student at an accredited institution of higher learning, the coverage may continue while the child remains unmarried and a full-time student, but not beyond the premium period in which the child reaches the age of twenty-three (23).~~

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

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

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

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

~~(5)(A) No person is eligible for coverage under the plan unless such person has been rejected by at least two (2) insurers for coverage substantially similar to the plan coverage without material underwriting restriction at a rate equal to or less than the pool plan rate; and~~

~~(B) No person is eligible for coverage who has, on the date of issue of coverage under the plan, equivalent coverage under another contract~~

~~or policy.~~

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

~~§ 23-79-510. Policy renewal - Coverage - Charges - Expenses - Deductibles.~~

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

~~(2)(A) Any person whose health insurance is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan.~~

~~(B) If such coverage is applied for within sixty (60) days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of the termination of the previous coverage.~~

~~(3) The plan shall provide that, upon the death or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within sixty (60) days to continue under the same or a different contract.~~

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

~~(b)(1)(A) The plan shall offer major medical expense coverage to every eligible person who is not eligible for Medicare.~~

~~(B) Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under subsection (e) of this section up to a lifetime limit of five hundred thousand dollars ($500,000) per covered individual.~~

~~(C) The maximum limit under this subsection shall not be altered by the board, and no actuarially equivalent benefit may be substituted by the board.~~

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

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

~~(A) Hospital services;~~

~~(B) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a physician or by others at his direction;~~

~~(C) Drugs requiring a physician's prescription;~~

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

~~(E) Services of a home health agency, of which the services are of a type which would qualify as reimbursable services under Medicare;~~

~~(F) Use of radium or other radioactive materials;~~

~~(G) Oxygen;~~

~~(H) Anesthetics;~~

~~(I) Prostheses, other than dental prostheses;~~

~~(J) Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;~~

~~(K) Diagnostic X rays and laboratory tests;~~

~~(L) Oral surgery for partially or completely erupted impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth;~~

~~(M) Services of a physical therapist;~~

~~(N) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;~~

~~(O) Processing of blood, including, but not limited to, collecting, testing, fractioning, and distributing blood; and~~

~~(P) Services for the treatment of alcohol and drug abuse, but:~~

~~(i) The insured shall be required to make a fifty percent (50%) copayment; and~~

~~(ii) The payment of the plan shall not exceed four thousand dollars ($4,000).~~

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

~~(d) Covered expenses shall not include the following:~~

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

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

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

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

~~(5) Any charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the services or articles;~~

~~(6) Any expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred;~~

~~(7) Any charge for routing physical examinations;~~

~~(8)(A) Any charge for the services of blood donors; and~~

~~(B) Any fee for the failure to replace the first three (3) pints of blood as provided to an eligible person annually; or~~

~~(9) Any charge for personal services or supplies provided by a hospital or nursing home, or any other nonmedical or nonprescribed services or supplies.~~

~~(e)(1) The plan shall provide for a choice of annual deductibles for major medical expenses in the amount of one thousand dollars ($1,000), five thousand dollars ($5,000), and ten thousand dollars ($10,000), plus the benefits payable under any other type of insurance coverage or workers' compensation; provided, if two (2) individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calendar year.~~

~~(2) The schedule of premiums and deductibles shall be established by the board.~~

~~(3) Rates for coverage issued by the pool may not be unreasonable in relation to:~~

~~(A) The benefits provided;~~

~~(B) The risk experience; and~~

~~(C) The reasonable expenses of providing coverage.~~

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

~~(5) Rates are subject to approval by the Insurance Commissioner.~~

~~(f) The coverage provided by the plan shall be directly insured by the pool, and the policies administered through the administering insurer.~~

SECTION 18. It is hereby found and determined by the General Assembly that the federal Health Insurance Portability and Accountability of 1996 becomes effective on July 1, 1997; that it is necessary that this Act become effective at the same time as the federal act; and that unless this emergency clause is adopted this Act will not go in effect until after July 1. Therefore an emergency is hereby declared to exist and this Act being immediately necessary for the public peace, health, and saftey shall become effective on July 1. 1997.

/s/Rep. Young

APPROVED:2-27-97