

Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

1 State of Arkansas
2 84th General Assembly
3 Regular Session, 2003
4

As Engrossed: H3/31/03 H4/3/03

A Bill

Act 1327 of 2003
HOUSE BILL 2279

5 By: Representative Napper
6
7

For An Act To Be Entitled

9 AN ACT TO EXTEND HEALTH INSURANCE POOL
10 ELIGIBILITY TO INDIVIDUALS WHO ARE ELIGIBLE FOR
11 TAX CREDITS FOR HEALTH INSURANCE COVERAGE UNDER
12 THE TRADE ADJUSTMENT ASSISTANCE REFORM ACT OF
13 2002; TO MAKE THE POOL ELIGIBLE FOR FEDERAL FUNDS
14 TO OFFSET LOSSES TO THE POOL; AND FOR OTHER
15 PURPOSES.

Subtitle

16
17
18 TO EXTEND POOL ELIGIBILITY TO
19 INDIVIDUALS WHO ARE ELIGIBLE FOR CERTAIN
20 FEDERAL TAX CREDITS FOR HEALTH INSURANCE
21 COVERAGE; TO MAKE THE POOL ELIGIBLE FOR
22 FEDERAL FUNDS TO OFFSET LOSSES TO THE
23 POOL.

24
25
26 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
27

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

30 23-79-501. Purpose.

31 (a)(1) Act 1339 of 1995 established the Arkansas Comprehensive Health
32 Insurance Pool as a state program that was intended to provide an alternate
33 market for health insurance for certain uninsurable Arkansas residents, and
34 further this subchapter is intended to provide for the successor entity that
35 will provide the acceptable alternative mechanism as described in the federal
36 Health Insurance Portability and Accountability Act of 1996 for providing



1 portable and accessible individual health insurance coverage for federally
2 eligible individuals as defined in this subchapter.

3 (2) This subchapter further is intended to provide a health
4 insurance coverage option for persons eligible for a federal income tax
5 credit under section 35 of the Internal Revenue Code, as created by the Trade
6 Adjustment Assistance Reform Act of 2002 or as subsequently amended.

7 (b) The General Assembly declares that it intends for this program to
8 provide portable and accessible individual health insurance coverage for
9 every ~~federally eligible~~ individual who qualifies for coverage in accordance
10 with § 23-79-509(b) as a federally eligible individual or as a qualified
11 trade adjustment assistance eligible person, but does not intend for every
12 eligible person who qualifies for pool coverage in accordance with § 23-79-
13 509 to be guaranteed a right to be issued a policy under this pool as a
14 matter of entitlement.

15
16 SECTION 2. Arkansas Code § 23-79-503, relating to Definitions, is
17 amended to read as follows:

18 23-79-503. Definitions.

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

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

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

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

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

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

36 (6) "Covered person" means a person who is and continues to

1 remain eligible for pool coverage and is covered under one (1) of the plans
2 offered by the pool;

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

6 (i) A group health plan;

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

9 (iii) Medicare;

10 (iv) Medical assistance;

11 (v) 10 U.S.C. § 1071 et seq.;

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

14 (vii) A state health benefits risk pool;

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

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

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

23 (B) Creditable coverage does not include:

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

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

31 (b) Any period that an individual is in a
32 waiting period for any coverage under a group health plan or for group health
33 insurance coverage or is in an affiliation period under the terms of health
34 insurance coverage offered by a health maintenance organization shall not be
35 taken into account in determining if there has been a break of more than
36 sixty-three (63) days in any creditable coverage;

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

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

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

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

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

15 (B) Who is not eligible for coverage under:

16 (i) A group health plan;

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

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

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

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

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

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

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

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

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

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

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

15 (15) "Hospital" shall have the same meaning as defined in § 20-
16 9-201;

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (23) "Plan administrator" means the insurer designated under §
22 23-79-508 to carry out the provisions of the plan of operation;

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

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

29 (26) "Qualified high risk pool" has the same meaning given that
30 term in the federal Health Insurance Portability and Accountability Act of
31 1996; ~~and~~

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

1 coverage of sixty-three (63) days or more;

2 ~~(27)~~(28) "Resident eligible person" means a person who:

3 (A) Has been legally domiciled in the State of Arkansas

4 ~~for~~;

5 (i) For a period of at least ~~thirty (30)~~ ninety (90)
6 days and continues to be domiciled in Arkansas; ~~and or~~

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

11 (B) Is not eligible for coverage under:

12 (i) A group health plan;

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

14 (iii) Medical assistance as defined in this section
15 and does not have other health insurance coverage as defined in this
16 section; and

17 (29) "Trade adjustment assistance eligible person" means a
18 person who is legally domiciled in the State of Arkansas on the date of
19 application to the pool and is eligible for the tax credit for health
20 insurance coverage premiums under section 35 of the Internal Revenue Code of
21 1986.

22
23 SECTION 3. Arkansas Code § 23-79-507, relating to the funding of the
24 pool, is amended to read as follows:

25 23-79-507. Funding of pool.

26 (a) Premiums.

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

33 (2)(A) The pool, with the assistance of the commissioner, shall
34 determine a standard risk rate by considering the premium rates charged by
35 other insurers offering health insurance coverage to individuals in Arkansas.
36 The standard risk rate shall be established using reasonable actuarial

1 techniques and shall reflect anticipated experience and expenses for the
2 coverage.

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

12 (b) Sources of Additional Revenue.

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

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

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

34 (4) If assessments or other funds received under either or both
35 subdivisions (b)(9) or (e) of this section or any combination of the
36 assessments and funds exceed the pool's actual losses and administrative

1 expenses, the excess shall be held at interest and used by the board to
2 offset future losses or to reduce future assessments. As used in this
3 subsection, "future losses" includes reserves for incurred but not reported
4 claims.

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

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

13 (B) In the event an assessment against an insurer is
14 abated or deferred in whole or in part, the amount by which the assessment is
15 abated or deferred shall be assessed against the other insurers in a manner
16 consistent with the basis for assessments set forth in this subsection. The
17 insurer receiving the abatement or deferment shall remain liable to the plan
18 for the deficiency for four (4) years.

19 ~~(7) From July 1, 1997, until December 31, 1997, if the board~~
20 ~~issues an assessment upon insurers, the board will utilize the method of~~
21 ~~calculating the assessment consistent with the provisions set forth in this~~
22 ~~subchapter, provided however, for purposes of this interim period assessment,~~
23 ~~insurers shall be defined as any individual, corporation, association,~~
24 ~~partnership, fraternal benefits society, or any other entity engaged in the~~
25 ~~health insurance business, except insurance agents or brokers. This term~~
26 ~~shall also include medical services plans, hospital plans, health maintenance~~
27 ~~organizations, and self insurance arrangements, which shall be designated as~~
28 ~~engaged in the business of insurance for the purposes of this interim period~~
29 ~~assessment.~~ For all assessments issued by the board, beginning January 1,
30 1998, only those individuals, corporations, associations, or other entities
31 defined as an insurer in § 23-79-503(17) shall be subject to assessment.

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

36 (9) The General Assembly further intends that the Comprehensive

1 Health Insurance Pool be eligible for, and for the pool, its board, or other
2 officers of state government, as appropriate, to take steps necessary to
3 obtain, federal grant funds to offset losses of the pool, including such
4 funds made available under the Trade Adjustment Assistance Reform Act of
5 2002.

6 (c) Assessment Offsets.

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

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

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

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

29 (2) The board and the commissioner shall have the authority to
30 enforce the collection of the assessment and penalty in accordance with the
31 provisions of this subchapter and the Arkansas Insurance Code, § 23-60-101 et
32 seq. The board may waive the penalty authorized by this subsection if it
33 determines that compelling circumstances exist which justify the waiver.

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

35 (1)(A) Following the close of each fiscal year, the board and
36 the plan administrator shall determine whether the pool has incurred a

1 deficit as calculated under subdivision (b)(2) of this section.

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

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

16
 17 SECTION 4. Arkansas Code § 23-79-509, relating to the plan
 18 eligibility, is amended to read as follows:

19 23-79-509. Plan eligibility.

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

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

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

1 condition; or

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

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

9 (C) Evidence that the applicant was covered under a
10 Qualified High Risk Pool of another state, provided the coverage terminated
11 no more than sixty-three (63) days prior to the date the pool receives the
12 applicant's application for coverage, and the other state's Qualified High
13 Risk Pool did not terminate the person's coverage for fraud;

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

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

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

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

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

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

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

35 (E) The plan has paid a total of one million dollars
36 (\$1,000,000) in benefits on behalf of the covered person;

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

2 (G) The person's premium is paid for or reimbursed under
3 any government-sponsored program or by any government agency, foundation,
4 health care facility, or health care provider, except ~~as~~ premiums paid on
5 behalf of Trade Adjustment Assistance Eligible Persons or Qualified Trade
6 Adjustment Assistance Eligible Persons in accordance with section 35 of the
7 Internal Revenue Code, or on behalf of an otherwise qualifying full-time
8 employee or dependent of such an employee of a government agency, foundation,
9 health care facility, or health care provider;

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

14 (4) Coverage shall cease:

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

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

18 (C) On the death of the covered person;

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

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

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

28 (b) ~~Federally Eligible Individual~~ Persons eligible for guaranteed
29 issuance of coverage. The following requirements apply to a federally
30 eligible individual or a qualified trade adjustment assistance eligible
31 person in order for such individual to be eligible for plan coverage:

32 (1) Notwithstanding the requirements of subsection (a) of this
33 section, any federally eligible individual or a qualified trade adjustment
34 assistance eligible person for whom a plan application, and such enclosures
35 and supporting documentation as the board may require, is received by the
36 board within sixty-three (63) days after the termination of prior creditable

1 coverage for reasons other than nonpayment of premium or fraud that covered
2 the applicant shall qualify to enroll in the plan under the portability
3 provisions of this subsection;

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

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

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

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

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

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

1 subsection;

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

7 (7) ~~Federally eligible individuals~~ Individuals who qualify and
8 enroll in the plan pursuant to this subsection shall be required to pay such
9 premium rates as the board shall establish and approve in accordance with the
10 requirements of § 23-79-507(a); ~~and~~

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

15 ~~(8)(9)~~ A federally eligible individual who qualifies and enrolls
16 in the plan pursuant to this subsection must continue to satisfy all of the
17 other eligibility requirements of this subchapter to the extent not
18 inconsistent with the federal Health Insurance Portability and Accountability
19 Act of 1996 in order to maintain continued eligibility for coverage under the
20 plan.

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

25

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

28 (f) Preexisting Conditions.

29 (1) Except for federally eligible individuals or qualified trade
30 adjustment assistance eligible persons qualifying for plan coverage under §
31 23-79-509(b) or resident eligible persons or trade adjustment assistance
32 eligible persons who qualify for and elect to purchase the waiver authorized
33 in subdivision (f)(2) of this section, plan coverage shall exclude charges or
34 expenses incurred during the first six (6) months following the effective
35 date of coverage as to any condition if:

36 (A) The condition has manifested itself within the six-

1 month period immediately preceding the effective date of coverage in such a
2 manner as would cause an ordinary prudent person to seek diagnosis, care, or
3 treatment; or

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

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

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

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

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

23 (3)(A) Whenever benefits are due from the plan because of
24 sickness or an injury to a covered person resulting from a third party's
25 wrongful act or negligence and the covered person has recovered or may
26 recover damages from a third party or its insurance carrier or self-insured
27 entity, the plan shall have the right to reduce benefits or to refuse to pay
28 benefits that otherwise may be payable in the amount of damages that the
29 covered person has recovered or may recover regardless of the date of the
30 sickness or injury or the date of any settlement, judgment, or award
31 resulting from that sickness or injury.

32 (B)(i) During the pendency of any action or claim that is
33 brought by or on behalf of a covered person against a third party or its
34 insurance carrier or self-insured entity, any benefits that would otherwise
35 be payable except for the provisions of this subsection shall be paid if
36 payment by or for the third party has not yet been made and the covered

1 person or, if capable, that person's legal representative agrees in writing
2 to pay back properly the benefits paid as a result of the sickness or injury
3 to the extent of any future payments made by or for the third party for the
4 sickness or injury.

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

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

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

13
14 SECTION 6. The Senate and House Interim Committees on Insurance and
15 Commerce shall conduct a study of the Arkansas Comprehensive Health Insurance
16 Pool for the purpose of determining alternative permanent funding sources for
17 the deficits incurred by the Arkansas Comprehensive Health Insurance Pool in
18 the future.

19
20 SECTION 7. EMERGENCY CLAUSE. It is found and determined by the
21 General Assembly that Arkansas residents who qualify for a federal tax credit
22 for health insurance coverage because of loss of their jobs or other reasons
23 should have access to coverage so that they can use the credit for themselves
24 and qualifying members of their families; that making the residents eligible
25 for enrollment in the Comprehensive Health Insurance Pool will allow them to
26 obtain coverage and make use of their tax credits should other coverage not
27 be available to them; and that the federal tax credits are now available. It
28 is further found that the Arkansas Comprehensive Health Insurance Pool
29 sustains significant operating losses because the limited premiums it can
30 charge cannot cover the medical costs of the population it insures; that the
31 Trade Adjustment Assistance Act of 2002 provides grant funds for some of the
32 losses sustained by qualifying state health insurance pools during federal
33 fiscal years 2003 and 2004; and that necessary revisions to the Arkansas
34 Comprehensive Health Insurance Pool Act should be made immediately so that
35 the Pool can qualify for these grants. Therefore, an emergency is declared
36 to exist and this act being immediately necessary for the preservation of the

1 public peace, health, and safety shall become effective on:

2 (1) The date of its approval by the Governor;

3 (2) If the bill is neither approved nor vetoed by the Governor,
4 the expiration of the period of time during which the Governor may veto the
5 bill; or

6 (3) If the bill is vetoed by the Governor and the veto is
7 overridden, the date the last house overrides the veto.

8 /s/ Napper

11 APPROVED: 4/14/2003