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State of Arkansas
78th General Assembly
Regular Session, 1991
By: Representative Dave Roberts

A BillACT 238 OF 1991

HOUSE BILL 1117

For An Act To Be Entitled

"AN ACT RELATING TO MINIMUM BASIC BENEFIT POLICIES AND SUBSCRIPTION CONTRACTS; AND FOR OTHER PURPOSES."

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

SECTION 1. LEGISLATIVE FINDINGS. The General Assembly finds that the cost of health insurance coverage is not affordable for many small businesses, their employees, self employed persons and other individuals, and that as a result hundreds of thousands of Arkansas citizens do not have any health insurance coverage. It is the intent of the General Assembly to reduce the cost of health insurance for these citizens by (a) authorizing the development of new classes of hospital and medical insurance coverage for qualified groups, families and individuals; and (b) authorizing the Arkansas Insurance Commissioner to develop means to assist in limiting the marketing and administrative costs of certain of such new classes of insurance coverage.

SECTION 2. DEFINITIONS. As used in this act:

(1) "COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985;

(2) "Commissioner" shall mean the Arkansas Insurance Commissioner;

(3) "Insured" shall mean any individual or group insured under a minimum basic benefit policy issued pursuant to the provisions of this act;

(4) "Insurer" means an insurer, health maintenance organization, hospital or medical services corporation offering a minimum basic benefit policy pursuant to this act;

(5) "Loss Ratio" means the percentage derived by dividing incurred claims (both reported and not reported) by total premiums earned;

(6) "Permitted Coverages" shall mean health or hospitalization coverage

under a minimum basic benefit policy issued pursuant to this act, under medicaid, medicare, limited benefit policies as defined by rules and regulations of the Commissioner, COBRA or the provisions of Ark. Code Ann. 23-86-114, 23-86-115 or 23-86-116;

(7) "Minimum Basic Benefit Policy" shall mean a policy or subscription contract which an insurer, may choose to offer to a qualified individual, qualified family, or qualified group pursuant to the provisions of this act;

(8) "Qualified Family" means individuals all of whom are qualified individuals and all of whom are related by blood, marriage, or adoption;

(9) "Qualified Group" means a group, organized other than pursuant to Section 4 of this act, in which each covered individual, or covered dependent of such covered individual, within the group is a qualified individual; provided a "qualified group" may include less than all employees of an employer;

(10) "Qualified Individual" means an individual who is employed in or is a resident of Arkansas and who has been without health insurance coverage, other than Permitted Coverage, for the twelve (12) month period immediately preceding the effective date of a minimum basic benefit policy issued pursuant to this act and who meets reasonable underwriting standards; provided, children newborn to or adopted by an insured after the effective date of a policy issued to the insured pursuant to this act which covers the insured and members of the insured's family, shall be considered qualified individuals;

(11) "Qualified Trust" means a group organized pursuant to Section 4 of this Act in which each covered individual, or covered dependent of such covered individual, within the group is a qualified individual.

(12) "Children's Preventive Health Care Services" means physician-delivered or physician-supervised services for eligible dependents from birth through age six (6), with periodic physical examinations including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section; and

(13) "Periodic Physical Examinations" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

SECTION 3. ISSUANCE OF MINIMUM BASIC BENEFIT POLICIES PERMITTED.

Insurers are hereby authorized to issue minimum basic benefit policies pursuant to and in compliance with the provisions of this act to qualified individuals, qualified families, qualified trusts, and qualified groups. This act shall apply only to those minimum basic benefit policies issued under this act and regulations issued by the commissioner pursuant to the authority of this act. Nothing in this act shall be deemed to add to, detract from, or in any manner apply to policies, subscription contracts, benefits, or related activities under any other statutory, or regulatory authorities.

SECTION 4. FORMATION OF QUALIFIED GROUPS SOLELY FOR INSURANCE PURPOSES. Solely for purposes of obtaining minimum basic benefit policies pursuant to the authority granted by this act,trusts may be formed composed of qualified individuals, qualified families, and/or qualified groups. Each trust may serve as a master policy holder. Members of qualified groups and members of such trusts may join together solely for the purpose of obtaining health insurance coverage under the provisions of this act; provided, the Commissioner shall adopt rules and regulations governing the formation and operation of such trust to assure the protection of persons purchasing policies pursuant to this act.

SECTION 5. COVERAGE REQUIRED UNDER POLICIES ISSUED PURSUANT TO THIS ACT. (a) Minimum basic benefit policies offered under the authority of this act shall provide basic levels of primary, preventive, and hospital care, including, but not limited to, the following:

(1) Fifteen (15) days of inpatient hospitalization coverage per policy year; and

(2) As an option, prenatal care, including one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month until term. Coverage for each such visit shall include necessary and appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member. Coverage for each office visit shall also include such prenatal counseling as the physician

deems appropriate; and

(3) As an option, obstetrical care, including physicians' services, delivery room and other medically necessary hospital services; and

(4) As an option, coverage for children's preventive health care services on a periodic basis from birth through age six (6) including thirteen (13) visits at approximately the following age intervals: birth, two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, eighteen (18) months, two (2) years, three (3) years, four (4) years, five (5) years, and six (6) years. The option may provide that children's preventive health care services which are rendered during a periodic review shall only be covered to the extent that these services are provided by or under the supervision of a single physician during the course of one (1) visit; and, that such benefits shall be reimbursed at levels established by the commissioner which shall not exceed those established for the same services under the medicaid program in the State of Arkansas. Copayment and deductible amounts shall not be greater than copayments and deductibles imposed for other physician's office visits; and

(5) A basic level of primary and preventive care, including two (2) office visits per calendar year for covered services rendered by a provider licensed to provide the services rendered; and

(6) Annual, lifetime or other benefit limits in amounts not less than may be established by the commissioner but which initially shall be not less than one hundred thousand dollars ($100,000) as an annual benefit, and two hundred fifty thousand dollars ($250,000) as a lifetime benefit; and

(7) Such waiting period, if any, as the commissioner may establish for transferring from any minimum basic benefit policy issued under this act by one insurer to a minimum basic benefit policy issued under this act by another insurer; and

(8) Every policy issued pursuant to this act which covers the insured and members of the insured's family shall include coverage for newborn infant children of the insured from the moment of birth, and for adopted minors from the date of the interlocutory decree of adoption, provided, the insurer may require that the insured give notice to his insurer of any newborn children within ninety (90) days following the birth of such newborn infant and of any adopted child within sixty (60) days of the date the insured has

filed a petition to adopt. The coverage of newborn children or adopted children shall not be less than the same as is provided for other members of the insured's family; and

(9) Such provisions, if any, as the commissioner may require for an annual or other deductible or equivalent; patient co-payments, including a differential, if any, for non-preferred providers; annual stop loss amounts; continuation of coverage; conversion; replacement of prior carrier's coverage; exclusionary periods for pre-existing conditions; and continuation of benefits.

(b) Notwithstanding the provisions of Section 5.(a) of this act, the commissioner shall consider the cost impact and essential nature of each of such requirements as well as the competitive impact of such requirements, and may vary any of such requirements,add, fix or remove requirements or establish alternative benefit methods to encourage participation of insurers in a manner consistent with meeting the goal of providing minimum basic health services at an affordable price to those eligible for coverage under this act.

(c) The commissioner may authorize a waiver of any of the policy provisions required pursuant to this Section 5 or the commissioner's authority under this section in order to authorize a minimum basic benefit policy to be issued as a medicaid supplement without requiring redundant coverage.

(d) Any minimum basic benefit policy issued pursuant to the provisions of this act may be issued without the provision of the benefits or requirements mandated by the following statutes of the State of Arkansas to be included in or offered to be included in disability insurance or health maintenance organization policies or subscription contracts, or regulations issued pursuant to such statutes: Ark. Code Ann. 23-79-129, 23-79-130, 23-79-137, 23-79-139, 23-79-140, 23-79-141, 23-85-131(b), 23-85-137, 23-86-108(4)and (7), 23-86-113, 23-86-114, 23-86-115, 23-86-116, and 23-86-118; provided, nothing in this act shall reduce any professional scope of practice as defined in the licensure law for any health care provider, shall authorize any discrimination not permitted under Arkansas law in payment or reimbursement for services, or shall be construed to repeal or eliminate the application of the Arkansas freedom of choice legislation, Ark. Code. Ann. 23-79-114, or coordination of benefit statutes or regulations, to policies issued pursuant to this act.

SECTION 6. NOTICE OF MINIMUM BASIC BENEFIT POLICIES; PAYROLL DEDUCTION. (a) Those employers in the State of Arkansas that do not provide a portion of the cost of health insurance for their employees shall provide notice to their employees of the existence of the minimum basic benefit policy authorized by this act. Such notice shall be in a form prepared by the commissioner and may be provided to employees by posting at the place of employment or in any other reasonable manner.

(b) Any insured, or dependent of an insured ,under this act may provide written request to his or her employer to withhold the amount of premium on a minimum basic benefit policy from his or her paycheck along with written instructions for remittance of the premium, in which case the employer shall withhold the premium and remit the premium payment to the insurer, unless to do so would require the employer to make remittances to more than three different insurers.

(c) No employer required to make a remittance of a premium under the provisions of this act shall be required to make such remittances more often than once per month.

(d) Nothing in this act shall be construed to require or mandate in any way that an employer provide or pay any portion of the cost of a minimum basic benefit policy issued under this act.

(e) The Arkansas Employment Security Division, upon request by the commissioner, is authorized to provide a copy of the form of notice prepared by the commissioner to employers as the commissioner and the Arkansas Employment Security Department may agree upon.

SECTION 7. DISCRETIONARY MANAGED CARE PROVISIONS. (a) The insurer may include any or all of the following managed care provisions to control the cost of a minimum basic benefit policy issued pursuant to this act:

(1) An exclusion for services that are not medically necessary;

(2) A procedure for pre-authorization by telephone, to be confirmed in writing, by the insurer or its designee of any medical service the cost of which is anticipated to exceed a minimum threshold, except for services necessary to treat a medical emergency;

(3) A preferred panel of providers who have entered into written

agreements with the insurer to provide services at specified levels of reimbursement. With the exception of health maintenance organizations, participation in such preferred panel shall be open to all providers licensed to provide the services to be covered. Any such written agreement between a provider and an insurer shall contain a provision under which the parties agree that the insured individual or covered member will have no obligation to make payment for any medical service rendered by the provider that is determined not to be medically necessary; provided, however, that charges for medically necessary services received by the insured which are not covered by the minimum basic benefit policy shall be considered the responsibility of the insured; and

(4) A provision under which any insured who obtains medical services from a non preferred provider shall receive reimbursement only in the amount that would have been received had services been rendered by a preferred provider, less a differential, if any, in an amount to be approved by the commissioner but which may not exceed twenty-five percent (25%); provided, however, that charges for medically necessary services received by the insured which are not covered by the minimum basic benefit policy shall be considered the responsibility of the insured; and

(b) Nothing in this act shall be construed to prohibit an insurer from including in a minimum basic benefit policy other managed care and cost control provisions which, subject to the approval of the commissioner, have the potential to control costs in a manner which does not result in inequitable treatment of an insured under this act.

SECTION 8. DISCLOSURE REQUIREMENTS FOR MINIMUM BASIC BENEFIT POLICIES. (a) Before any insurer issues a minimum basic benefit policy, it shall obtain from the prospective insured a signed written statement, in a form approved by the commissioner, in which the prospective insured:

(1) Certifies as to eligibility for coverage under the minimum basic benefit policy;

(2) Acknowledges the limited nature of the coverage provided and an understanding of the managed care and cost control features of the minimum basic benefit policy;

(3) Acknowledges that if misrepresentations are made regarding

the insured's eligibility for coverage under a minimum basic benefit policy that the person making such misrepresentation shall forfeit coverage provided by the minimum basic benefit policy; and

(4) Acknowledges that the prospective insured, at the time of application for the minimum basic benefit policy, was offered the opportunity to purchase health insurance coverage which would have included all mandated or mandated optional benefits required by Arkansas law and that the prospective insured rejected such coverage.

(b) A copy of such written statement shall be provided to the prospective insured no later than at the time of minimum basic benefit policy delivery, and the original of such written statement shall be retained by the insurer for the longer of the period of time in which the minimum basic benefit policy remains in effect or five (5) years.

(c) At the time coverage under a minimum basic benefit policy shall take effect for an insured, the insurer shall provide such insured with a written disclosure statement containing such information as the commissioner shall require and in a form approved by the commissioner. The disclosure statement shall be separate from the insurance policy or evidence of coverage provided to such insured. The disclosure statement shall contain at least the following information:

(1) An explanation of those mandated or mandated optional benefits not covered by the minimum basic benefit policy but which would otherwise be required to be provided under Arkansas law;

(2) An explanation of the managed care and cost control features of the minimum basic benefit policy, along with all appropriate mailing addresses and telephone numbers to be utilized by the insured in seeking information or authorization, as well as a list of any preferred providers then contracting with the insurer, and an explanation of the obligations of the providers and the insured with regard to services determined not to be medically necessary; and

(3) An explanation of the primary and preventive care features of the minimum basic benefit policy.

(d) Any material statement made by an applicant for coverage under a minimum basic benefit policy which falsely certifies as to the applicant's eligibility for coverage under a minimum basic benefit policy shall serve as

the basis for termination of coverage under any minimum basic benefit policy issued to such applicant.

SECTION 9. FORMS, RATES, MARKETING COMMUNICATIONS TO BE FILED WITH AND APPROVED BY THE COMMISSIONER. (a) All minimum basic benefit policy forms, including applications, enrollment forms, policies, certificates, evidences of coverage, riders, amendments, endorsements, disclosure forms, and marketing communications used in connection with the sale or advertisement of a minimum basic benefit policy shall be submitted to the commissioner for approval in the same manner as required by Ark. Code Ann. Sec. 23-79-109 (a) or Ark. Code Ann. Sec. 23-76-112 (a).

(b) Minimum basic benefit policies are subject to the filing and approval statutes, rules and regulations of the state. No rate shall be considered reasonable nor shall it be approved unless:

(1) It is based upon a pool, community rating, or other rating formula acceptable to the commissioner; and

(2) As to individual policies and policies issued to qualified trusts, it is likely to produce a loss ratio, as certified by a qualified actuary, which is acceptable to the Commissioner, but in no event shall such loss ratio be less than sixty-five percent (65%); provided the Commissioner may set a minimum loss ratio for group policies issued pursuant to this act if he determines that inequitable or unfair treatment of policyholders would otherwise result.

(c) To the extent that an insurer has a surplus in a given year which has been generated on minimum basic benefit policies issued pursuant to this Act to a qualified group by a loss ratio of less than seventy-five percent (75%) or issued pursuant to this Act to qualified individuals, qualified families or qualified trusts by a loss ratio of less than sixty-five percent (65%), that surplus shall be taken into consideration in setting rates in following years in such manner as to benefit the holders of such minimum basic benefit policies.

(d) The commissioner may require that as to each minimum basic benefit policy approved, the insurer provide a statement of the portion of the rate or premium applicable to the minimum basic benefit policy coverage required by this act, or the commissioner pursuant to this act, or such other information

as the commissioner may require so that prospective purchasers of policies pursuant to this act may have an ability to make a direct comparison of the cost of the minimum basic benefits within policies of the same class issued by different insurers. The commissioner may include rate comparison or other cost information in the form of notice which may be provided by the commissioner to employers pursuant to this act.

SECTION 10. NOTICES AND HEARINGS. The commissioner shall provide notice and conduct hearings in accordance with the Arkansas Administrative Procedures Act, Ark. Code Ann. 25-15-201 et seq. before adopting any regulations of general applicability to minimum basic benefit policies to be issued pursuant to this act.

SECTION 11. RECORD-KEEPING AND REPORTING REQUIREMENT FOR INSURERS. Each insurer issuing a minimum basic benefit policy in this state shall maintain separate and distinct records of enrollment, claim costs, premium income, utilization, and such other information as may be required by the commissioner. Each insurer providing a minimum basic benefit policy shall furnish an annual report to the commissioner in a form prescribed by the commissioner which shall contain such information as the commissioner may require to analyze the effect of insurance coverage issued pursuant to this act. The annual report required shall be in a form consistent with the forms, if any, adopted by the National Association of Insurance Commissioners for such purpose.

SECTION 12. REPORT BY THE COMMISSIONER. The Insurance Commissioner is directed to make a written report by October 1, 1994 to the Governor and the General Assembly regarding the minimum basic benefit policies permitted by this act. In the report, the commissioner shall describe the extent to which minimum basic benefit policies have been purchased, the adequacy of the coverages under such policies and any recommendations by the commissioner with respect to the continuation, modification, or discontinuation of the minimum basic benefit policies permitted by this act.

SECTION 13. ARKANSAS CODE ANNOTATED. 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 14. SEVERABILITY. 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 15. APPLICATION TO OTHER LAWS. This act shall be supplemental to all other laws governing the issuance of health insurance coverage; provided, to the extent any law or parts of any law are in conflict with the provisions of this act, the provisions of this act shall govern.

SECTION 16. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that the cost of health insurance coverage is not affordable for many small businesses, their employees, self employed persons and other individuals; and that as a result hundreds of thousands of Arkansas citizens do not have any health insurance coverage; and that this act is immediately necessary to authorize new classes of hospital and medical insurance coverage so that qualified groups, families and individuals can obtain insurance coverage. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval.

/s/Dave Roberts

APPROVED: 2-27-91