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State of Arkansas
80th General Assembly

A Bill

Regular Session, 1995 HOUSE BILL 1354

By: Representatives Brown and Wagner

For An Act To Be Entitled

"AN ACT TO REPEAL THE CURRENT SMALL EMPLOYER GROUP DISABILITY INSURANCE ACT UNDER SUBCHAPTER 2 OF CHAPTER 86 OF TITLE 23 IN THE INSURANCE CODE; TO REPLACE IT WITH NEW SUBCHAPTER 3 OF CHAPTER 86 OF TITLE 23 IN THE INSURANCE CODE WITH THE NEW ACT ON SMALL EMPLOYER DISABILITY INSURANCE AVAILABILITY ACT; AND FOR OTHER PURPOSES."

Subtitle

"TO REPEAL ARKANSAS CODE 23-86-201 TO 23-86-209 & TO REPLACE IT IN A NEW SUBCHAPTER WITH A NEWER ACT ON SMALL EMPLOYER DISABILITY INSURANCE AVAILABILITY ACT."

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

SECTION 1. Subchapter 2 of Chapter 86 of Title 23 of the Insurance Code, Sections 23-86-201 through 23-86-209 on disability insurance policies for small employer groups, is hereby repealed.

SECTION 2. New Subchapter 3 of Chapter 86 of Title 23 of the Insurance Code, to enact a newer Act on Availability of Disability Insurance for Small Employer Groups, is hereby added to the Arkansas Code at the end of the existing Subchapter 1 of Chapter 86 of Title 23, to replace the just repealed Subchapter 2 of Chapter 86 of Title 23, to read as follows:

"23-86-301. Short Title. This Act shall be known and may be cited as the _Small Employer Disability Insurance Availability Act_."

23-86-302. Purpose. The purpose and intent of this Act are to assure

the availability of disability insurance coverage and health benefit plans to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to prevent segmentation of the disability insurance market based upon health risk, to spread disability insurance risk more broadly, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to limit the use of preexisting condition exclusions, to provide for development of _basic_ and _standard_ disability insurance and health benefit plans to be offered to all small employers, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group disability insurance and health benefit plan market. This Act is not intended to provide a comprehensive solution to the problem of affordability of health care or disability insurance.

23-86-303. Definitions. As used in this Act:

A. _Actuarial certification_ means a written statement signed by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of §23-86-305 of this subchapter, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

B. _Adjusted community rating_ means a method used to develop a carrier's premium which spreads financial risk across the carrier's entire small group population in accordance with the requirements in §23-86-305 (H) of this Act.

C. _Affiliate_ or _affiliated_ means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

D. _Basic health benefit plan_ means a lower cost health benefit plan developed pursuant to §23-86-311.

E. _Carrier_ or _small employer carrier_ means all entities licensed, or required to be licensed, by the State Insurance Department which offer health benefit plans or disability insurance covering eligible employees of one or more small employers pursuant to this Act. For the purposes of this Act, carrier includes an insurance company, a hospital or medical service

corporation, a fraternal benefit society, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to regulation by the insurance commissioner.

F. _Commissioner_ means the insurance commissioner of this state.

G. _Committee_ means the health benefit plan *advisory* committee created pursuant to §23-86-311.

H. _Control_ shall be defined in the same manner as in §23-63-503 (2).

I. _Dependent_ means a spouse; an unmarried child under the age of eighteen (18) years; an unmarried child who is a full-time student under the age of twenty-five (25) and who is financially dependent upon the enrollee; and an unmarried person of any age who is medically certified as disabled and dependent upon the enrollee. For purposes of this subsection, a child includes an individual to whom the enrollee stands in loco parentis, by virtue of a lawful court order establishing guardianship, adoption, paternity, or other court-ordered custodial relationship.

J. _Eligible employee_ means a permanent employee whose employment is expected to be continuous in nature and who works on a full-time basis with a normal work week of thirty (30) hours or more; and at the sole discretion of the employer, the term shall also include a permanent employee who works on a part-time basis less than thirty (30) hours per week so long as this eligibility criterion is applied uniformly among all of the employer's employees. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee whose work is not expected to be permanent or continuous in nature and who works on a temporary or substitute basis or who works less than *twenty-five (25)* hours per week. Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (_COBRA_) shall not be considered _eligible employees_ for purposes of minimum participation requirements pursuant to §23-86-307 (C) (4).

K. _Established geographic service area_ means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is

authorized to provide coverage.

L. _Family composition_ means:

(1) Enrollee;

(2) Enrollee, spouse and children;

(3) Enrollee and spouse; or

(4) Enrollee and children.

M. _Geographic area_ is an area established by the commissioner used for adjusting the rates for a health benefit plan.

N. (1) _Health benefit plan_ for purposes of this Act means any disability insurance policy or contract or certificate evidencing policy coverage issued by authorized disability insurers in this state, including licensed fraternal benefit societies, hospital or medical policy or certificate, major medical expense insurance, subscriber contract or contract of benefits provided by a hospital or medical service corporation, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicare Supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance. Health benefit plan does include short-term and catastrophic health insurance policies, and any policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

(2) _Health benefit plan_ shall not include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

(a) The carrier files on or before March 1 of each year a certification with the commissioner that contains the statement and information described in paragraph (b) of subdivision (O)(2) below in this section.

(b) The certification required in paragraph (a) of subdivision (O)(2) above in this section shall contain the following:

(i) A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for

hospital or medical expense insurance or major medical expense insurance; and

(ii) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age or other factors) charged for such policies and certificates in this state.

(c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of this subchapter, the carrier files with the commissioner the information and statement required in paragraph (b) of subdivision (O)(2) of this section at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state.

O. _Late enrollee_ means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(1)The individual meets each of the following:

(a) The individual was covered under qualifying previous coverage at the time of the initial enrollment *or was covered during any open enrollment in the current plan*;

(b) The individual lost coverage under qualifying previous coverage as a result of cessation of employer contribution, termination of employment or eligibility, involuntary termination of the qualifying previous coverage, or death of a spouse or divorce; and

(c) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage or the change in conditions that gave rise to the termination of coverage.

(2) Where provided for in contract or where otherwise provided in state law, the individual enrolls during the specified bona fide open enrollment period;

(3) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;

(4) A court has ordered coverage be provided for a spouse

or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order; or

(5) The individual changes status from not being an eligible employee to becoming an eligible employee and requests enrollment within thirty (30) days after the change in status.

P. _Limited benefit health insurance_ means that form of coverage that pays stated predetermined amounts for specific services or treatments or pays a stated predetermined amount per day or confinement for one or more named conditions, named diseases or accidental injury, or both.

Q. _Plan of operation_ means the plan of operation of the program established pursuant to §23-86-310.

R. _Premium_ means all monies paid by a small employer *and/or* eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

S. _Producer_ means agents, brokers and solicitors as defined in §§23-64-101, et seq.

T. _Program_ means the Arkansas Small Employer Reinsurance Program created by §23-86-310.

U. _Qualifying previous coverage_ and _qualifying existing coverage_ mean benefits or coverage provided under:

(1) Medicare, Medicaid, CHAMPUS, Indian Health Service program or any other similar publicly sponsored program;

(2) A group health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(3) An individual health insurance policy (including coverage issued by a health maintenance organization, hospital or medical service corporation, and fraternal benefit society) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan.

V. _Rating period_ means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

W. _Reinsuring carrier_ means a small employer carrier participating in the reinsurance program pursuant to §23-86-310.

X. _*Network* provision_ means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to §§23-76-101, et seq. as to health maintenance organizations, or to a preferred provider organization to provide health care services to covered individuals.

Y. _Risk adjustment mechanism_ means the mechanism established pursuant to §23-86-318 of this subchapter.

Z. _Risk-assuming carrier_ means a small employer carrier whose application is approved by the commissioner pursuant to §23-86-308 and §23-86-309.

AA. _Self-employed individual_ means an individual or sole proprietor who derives a substantial portion of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

BB. _Small employer_ means any person, firm, corporation, partnership, association, political subdivision or self-employed individual that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty (50)eligible employees, with a normal work week of thirty (30) or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this subchapter that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term small employer includes a self-employed individual.

CC. _Standard health benefit plan_ means a health benefit plan developed pursuant to §23-86-311.

§23-86-304. Applicability and Scope. This subchapter shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

A. Any portion of the premium or benefits is paid by or on behalf of the small employer;

B. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

C. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code; or

D. The health benefit plan is marketed to individual employees through an employer.

E. (1)Except as provided in subdivision (2) below , for the purposes of this subchapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this subchapter shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.

(2) An affiliated carrier that is a health maintenance organization having a certificate of authority under §§23-76-101, et seq., may be considered to be a separate carrier for the purposes of this subchapter.

(3) Unless otherwise authorized by the commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The provisions of §23-62-205 or §23-69-149 or §23-69-150 on bulk or assumption reinsurance shall apply if a small employer carrier cedes or assumes all of the insurance obligation or

risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.

§23-86-305. Restrictions Relating to Premium Rates.

A. Premium rates for health benefit plans subject to this subchapter shall be subject to the following provisions:

(1) The small group carrier shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(a) Geographic area;

(b) Family composition; and

(c) Age *and gender*.

(2) The adjustment for age in paragraph (c) above may not use age brackets smaller than five-year increments and these shall begin with age thirty (30) and end with age sixty-five (65).

(3) The small group carriers shall be permitted to develop separate rates for individuals age sixty-five (65) or older for coverage for which Medicare is the primary payor and coverage for which Medicare is not the primary payor. Both rates shall be subject to the requirements of this subsection (A).

(4) The adjustments to the rates for a health benefit plan permitted in paragraph (c) above shall not result in a rate per enrollee for the health benefit plan of more than 200 percent of the lowest rate for all age groups effective five (5) years after enactment of this Act. During the first two (2) years after enactment of this subchapter the permitted rates for any age group shall be no more than 400 percent of the lowest rate for all age groups and two (2) years after enactment of this subchapter the permitted rates for any age group shall be no more than 300 percent of the lowest rate for all age groups.

B. The premium charged for a health benefit plan may not be adjusted more frequently than annually except that the rates may be changed to reflect:

(1) Changes to the enrollment of the small employer;

(2) Changes to the family composition of the employee; or

(3) Changes to the health benefit plan requested by the small employer.

C. Premium rates for health benefit plans shall comply with the

requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to §23-86-310.

D. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

E. For the purposes of this section, a health benefit plan that contains a network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the benefits to network providers results in substantial differences in claim costs.

F. The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this subchapter, including regulations that:

(1) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design or coverage (not including differences due to the nature of the groups assumed to select particular health benefit plans or separate claim experience for individual health benefit plans); and

(2) Prescribe the manner in which geographic territories are designated by all small employer carriers.

G. In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(2) The provisions relating to renewability of policies and contracts;

(3) The provisions relating to any preexisting condition provision; and

(4) A listing of and descriptive information about all benefit plans for which the small employer is qualified.

H. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer carrier shall file with the commissioner annually on or before March 15th, an actuarial certification certifying that the carrier is in compliance with this subchapter and that the rating methods of the small employer carrier are actuarially sound. The certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business. The commissioner may grant a time extension for such filings for good cause shown.

(3) A small employer carrier shall make the information and documentation described in subdivision (F)(1) available to the commissioner upon request. Except in cases of violations of this subchapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

I. The requirements of this section shall apply to all health benefit plans issued or renewed on or after the effective date of this Act.

§23-86-306. Renewability of Coverage.

A. A health benefit plan subject to this subchapter shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

(1) Nonpayment of the required premiums;

(2) Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives;

(3) Noncompliance with the carrier's minimum participation requirements;

(4) Noncompliance with the carrier's employer contribution requirements;

(5) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:

(a) Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and

(b) Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subparagraph shall be provided at least three (3) working days prior to the notice to the affected small employers; or

(6) The commissioner finds that the continuation of the coverage would:

(a) Not be in the best interests of the policyholders or certificate holders; or

(b) Impair the carrier's ability to meet its contractual obligations.

In such instance the commissioner shall assist affected small employers in finding replacement coverage.

B. A small employer carrier that elects not to renew a health benefit plan under subdivision (A)(6) above shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of notice to the commissioner.

C. In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier's operations in that service area.

§23-86-307. Availability of Coverage.

A. (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state including at least two (2) health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan *with guaranteed issue* and one plan shall be a standard health benefit plan *with guaranteed issue*. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that

plan to any small employer not currently receiving a health benefit plan by such small employer carrier.

(2) Subject to subdivision (A)(1) above , a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this subchapter; provided, however, no carrier shall be required to issue a health benefit plan to any self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

(3) The provisions of this subsection shall be effective 180 days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to §23-86-311; provided, that if the Small Employer Health Reinsurance Program created pursuant to §23-86-310 is not yet operative on that date, the provisions of this subsection shall be effective on the date that the program begins operation.

B. (1) A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this subsection may be used by a small employer carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use.

(2) The commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this subchapter.

C. Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than six (6) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6)

months immediately preceding the effective date of coverage.

(2) A small employer carrier shall waive any carrier waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the period of time an individual was previously covered by qualifying previous coverage provided that the qualifying previous coverage was continuous to a date not more than ninety (90) days prior to the effective date of new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier, or for the normal application and enrollment process following employment or other triggering event for eligibility. A carrier that does not use preexisting condition limitations in any of its health benefit plans may impose an affiliation period.

Affiliation period means a period of time not to exceed sixty (60) days for new entrants and not to exceed one hundred and eighty (180) days for late enrollees during which no premiums shall be collected and coverage issued would not become effective. This subdivision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan, provided that any carrier-imposed waiting period be no longer than sixty (60) days and be used in lieu of a preexisting condition exclusion.

(3) A health benefit plan may exclude coverage for late enrollees for preexisting conditions for a period not to exceed twelve (12) months.

(4) (a) Except as provided in this paragraph, requirements used by a small employer carrier in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier.

(b) A small employer carrier shall not require a minimum participation level greater than:

(i) One hundred percent (100%) of eligible employees working for groups of three (3) or less employees; and

(ii) Seventy-five percent (75%) of eligible employees working for groups with more than three (3) employees.

(c) In applying minimum participation requirements with

respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(d) A small employer carrier shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(5) (a) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.

(b) Except as permitted under paragraphs (1) and (3) of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise *covered by the plan.*

(6) A health benefit plan shall provide an initial enrollment period for all current employees at the inception of plan coverage, as well as for each new employee hired subsequent to plan's inception. Annually and for a period of not less than thirty (30) days, a health benefit plan shall offer an open enrollment period at a time to be determined by the small employer carrier, during which an eligible employee may enroll in plan coverage without limitation due to pre-existing conditions or other such conditions.

D. (1) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (A) in the case of the following:

(a) To a small employer, where the small employer is not physically located in the carrier's established geographic service area;

(b) To an employee, when the employee does not work or reside within the carrier's established geographic service area; or

(c) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the

commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(2) A small employer carrier that cannot offer coverage pursuant to paragraph (1)(c) above may not offer coverage in the applicable area to new cases of employer groups with more than fifty (50) eligible employees or to any small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.

E. A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection (A) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (A) would place the carrier in a financially impaired condition.

§23-86-308. Notice of Intent to Operate as a Risk-Assuming Carrier or a Reinsuring Carrier.

A. (1) Within thirty (30) days after the plan of operation is approved by the commissioner under §23-86-311, each small employer carrier shall notify the commissioner of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to §23-86-309.

(2) The decision shall be binding for a five-year period except that the initial decision shall be binding for two (2) years. The commissioner may permit a carrier to modify its decision at any time for good cause shown.

(3) The commissioner shall establish as application process for small employer carrier seeking to change their status under this subsection. In the case of a small employer carrier that has been acquired by another such carrier, the commissioner may waive or modify the time periods established in Subsection (A) (2) above.

B. A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay a prorated

assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

§23-86-309. Application to Become a Risk-Assuming Carrier.

A. A small employer carrier may apply to become a risk-assuming carrier by filing an application with the commissioner in a form and manner prescribed by the commissioner.

B. The commissioner shall consider the following factors in evaluating an application filed under subsection (A):

(1) The carrier's financial condition;

(2) The carrier's history of rating and underwriting small employer groups;

(3) The carrier's commitment to market fairly to all small employers in the state or its established geographic service area, as applicable;

(4) The carrier's experience with managing the risk of small employer groups.

C. The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty-day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the commissioner, the carrier may request a hearing.

D. The commissioner may rescind the approval granted to a risk-assuming carrier under this section if the commissioner finds that:

(1) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with §23-86-307 without the protection afforded by the program;

(2) The carrier has failed to market fairly to all small employers in the state or its established geographic service area, as applicable; or

(3) The carrier has failed to provide coverage to eligible small employers as required in §23-86-307.

E. A small employer carrier electing to be a risk-assuming carrier

shall not be subject to the provisions of §23-86-310.

§23-86-310.Small Employer Carrier Reinsurance Program.

A. A reinsuring carrier shall be subject to the provisions of this section.

B. There is hereby created a nonprofit entity to be known as the Arkansas Small Employer Health Reinsurance Program.

C. The program shall be implemented by and operate subject to the control and supervision of the commissioner. He may operate the program through his office or he may contract for and procure on a basis of fee, such independently contracting actuarial, rate analysis, examination, technical and professional services as he may require to implement and operate the reinsurance program.

D. Within sixty (60) days of the effective date of this Act, each small employer carrier shall make a filing with the commissioner containing the carrier's net health insurance premium derived for health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

E. The commissioner or his designee or consultants shall prepare a plan of operation within one hundred and eighty (180) days after passage and approval of this act.

F. The plan of operation shall:

(1) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner;

(2) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(3) Establish procedures for reinsuring risks in accordance with the provisions of this section;

(4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program;

(5) Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers though capitation or salary; and

(6) Provide for any additional matters necessary for the implementation and administration of the program.

G. The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(3) Take any legal action necessary to avoid the payment of improper claims against the program;

(4) Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this Act;

(5) Establish rules, conditions and procedures for reinsuring risks under the program;

(6) Establish actuarial functions as appropriate for the operation of the program;

(7) Assess reinsuring carriers in accordance with the provisions of Subsection (L) below , and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(8) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program;

(9) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default may be carried as admitted assets;

H. A reinsuring carrier may reinsure with the program as provided for

in this subsection:

(1) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(2) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under a health benefit plan.

(3) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage.

(4) (a) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next $50,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subparagraph shall not exceed a maximum limit of $10,000 in any one calendar year with respect to any reinsured individual.

(b) The *commissioner* annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the _Consumer Price Index for All Urban Consumers_ of the Department of Labor, Bureau of Labor Statistics, unless the commissioner approves a lower adjustment factor.

(5) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(6) Premium rates charges for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300 (c)(2)(A), and as such is subject to requirements that limit the

amount of risk that may be ceded to the program that is more restrictive than those specified in subdivision (4), shall be reduced to reflect that portion of the risk above the amount set forth in subdivision (4) that may not be ceded to the program, if any.

(7) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

I. (1) The *commissioner*, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in subdivision (2) to determine the premium rates for the program. The base reinsurance premium rates shall be established by the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan (adjusted to reflect retention levels required under this Act).

(2) Premiums for the program shall be as follows:

(a) An entire small employer group may be reinsured for a rate that is one and one-half (1.5) times the base reinsurance premium rate for the group established pursuant to this subdivision.

(b) An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this subdivision.

(3) The *commissioner* periodically shall review the methodology established under subdivision (1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims *experience of the program. Proposed changes to the methodology shall be reviewed for the commissioner's approval.*

(4) The *commissioner* may consider adjustments to the premium

rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

J. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in §23-86-305.

K. (1) Prior to March 1 of each year, the *commissioner shall determine* the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(2) Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(a) The *commissioner* shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:

(i) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and

(ii) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.

(b) The formula established pursuant to paragraph (a) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than 150 percent (150%) of an amount which is based on the proportion of (i) the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (ii) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(c) The commissioner may change the assessment formula established pursuant to paragraph (a) from time to time as appropriate. The *commissioner* may provide for the shares of the assessment base attributable

to total premium and to the previous year's premium to vary during a transition period.

(d) Subject to the approval of the commissioner, the *program* shall make an adjustment to the assessment formula for reinsuring carriers which are approved health maintenance organizations which are federally qualified under 42 U.S.C. Sec. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(3) (a) Prior to March 1 of each year, the *commissioner shall determine* an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(b) If the *commissioner* determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in paragraph (c), the *commissioner* shall evaluate the *operation of the program. The commissioner shall evaluate and consider for adoption changes in the plan of operation within ninety (90) days following the end of the calendar year in which the losses occurred.* The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. *The commissioner may evaluate the* operations of the program and implement such amendments to the plan of operation the commissioner deems necessary to reduce future losses and assessments.

(c) For any calendar year, the amount specified in this subparagraph is five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(4) If assessments exceed net losses of the program, the excess shall be held at interest and used by the *commissioner* to offset future losses or to reduce program premiums. As used in this paragraph, `future losses' includes reserves for incurred but not reported claims.

(5) Each reinsuring carrier's proportion of the assessment shall be determined annually by the *commissioner* based on annual statements and other reports deemed necessary by the *commissioner* and filed by the

reinsuring carriers with the *commissioner*.

(6) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(7) A reinsuring carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the *program*. The commissioner may defer all or part of the assessment of a reinsuring carrier if the commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subdivision. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.

L. Neither the participation in the program as reinsuring carriers, 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 program or any of its reinsuring carriers either jointly or separately.

M. The program shall be exempt from any and all taxes.

§23-86-311.Health Benefit Plan Committee.

A. The Governor shall appoint a Health Benefit Plan *Advisory* Committee. The committee shall be composed of representatives of carriers, small employers and employees, health care providers and producers.

B. The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to §23-86-307.

C. The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(1) The plans recommended by the committee may include cost

containment features such as:

(a) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(b) Case management;

(c) Other managed care provisions. Provided, however, no provision may be included which imposes a monetary advantage or penalty on an eligible employee or a dependent that would affect their choice among Health Care Providers who participate in a small group disability insurance or health benefit plan. Monetary advantage or penalty includes higher co-payment, a reduction in reimbursement for services, or promotion of one Health Care Provider over another by these methods. No provision shall prohibit or limit a Health Care Provider who is willing to accept the plan's operating terms and conditions, its schedule of fees, covered expenses, utilization regulations and quality standards from the opportunity to participate in a health benefit plan.

(2) The committee shall submit the health benefit plans described in subdivision (1) to the commissioner for approval within 180 days after the appointment of the committee.

§23-86-312.Periodic Market Evaluation.

All program consultants, in consultation with members of the committee, shall study and report at least every three (3) years to the commissioner on the effectiveness of this Act. The report shall analyze the effectiveness of the Act in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group health insurance marketplace. The report shall address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the Act. The report may contain recommendations for market conduct or other regulatory standards or action.

§23-86-313.Waiver of Certain State Laws.

No law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, shall apply to a basic health benefit plan delivered or issued for delivery to small employers in this state

pursuant to this Act.

§23-86-314.Administrative Procedures.

The commissioner shall issue regulations in accordance with Arkansas Code 23-61-108, and Arkansas Code 25-15-201, and following, for the implementation and administration of the Small Employer Health Coverage Reform Act.

§23-86-315.Standards to Assure Fair Marketing.

A. Subject to §23-86-306 (A)(1), each small employer carrier shall actively market all health benefit plans sold by the carrier to eligible small employers in the state.

B. (1) Except as provided in subdivision (2), no small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;

(b) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) The provisions of subdivision (1) shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

C. (1) Except as provided in Subdivision (2), no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the initial or renewal health status, claims experience, industry, occupation or geographic location of the small employer.

(2) Subdivision (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or

geographic area of the small employer.

D. No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the initial or renewal health status, claims experience, occupation or geographic location of the small employers placed by the producer with the small employer carrier.

E. A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee or dependent from health coverage or benefits provided in connection with the employee's employment.

F. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

G. The commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

H. (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under §§23-66-201, et seq.

(2) If a small employer carrier enters into a contract, agreement or other arrangement with a third party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third party administrator shall be subject to this section as if it were a small employer carrier. Further, such third party administrator shall register with the commissioner as required by §§23-92-201, et seq.

§23-86-317. Restoration of Terminated Coverage.

The commissioner may promulgate regulations to require small employer carriers, as a condition of transacting business with small employers in this state after the effective date of this subchapter to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after October 1, 1994. The commissioner may prescribe such terms for the reissue of coverage as the commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

§23-86-318. Risk Adjustment Mechanism.

The commissioner may establish a payment mechanism to adjust for the amount of risk covered by each small employer carrier. The commissioner may appoint an advisory committee composed of individuals that have risk adjustment and actuarial expertise to help establish the risk adjusters.

§23-86-319. Effective Date. The provisions of this subchapter shall apply to each health insurance policy or plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state after January 1, 1996. For purposes of this section, the date a plan is continued is the first rating period which commences after January 1, 1996."

SECTION 3. 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 4. 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 application of the Act which can be given effect without the invalid provision or application, and to this end the provisions of the Act are declared to be severable.

SECTION 5. All laws and parts of laws in conflict with this Act are hereby repealed.

SECTION 6. Emergency. It is hereby found and determined that the current small employer premium rating and availability law of this State is inadequate; that since the initial passage of the NAIC Model Small Employer Group law in Arkansas in 1991, the NAIC has proposed several amendments which would make the current small employer law in Arkansas out of date; and it is necessary to replace that obsolete version of the law with the more current new draft. Therefore since it is determined that the current insurance laws are inadequate for the protection of the public and the immediate passage of this Act is necessary to provide for the protection of the public, an emergency is hereby declared to exist; and this Act being immediately necessary for the preservation of the public peace, health and safety shall be in effect from and after its passage and approval.

/s/Rep. Brown, et al