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State of Arkansas
80th General Assembly
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A Bill

HOUSE BILL 2009

By: Representative Young
By: Senators Boozman, Hunter, Dowd, Wilson, and Canada

For An Act To Be Entitled

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

Subtitle

"COMPREHENSIVE HEALTH INSURANCE POOL ACT."

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

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

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

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

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

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

(D) "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the

health insurance business, except insurance agents and brokers. This term shall also include medical services plans, hospital plans, health maintenance organization and self-insurance arrangements, which shall be designated as engaged in the business of insurance for the purposes of this act.

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

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

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

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

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

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

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

(1) the insured_s spouse;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) one (1) member to represent a group considered to

be "uninsurable."

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

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

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

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

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

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

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

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

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

SECTION 6. The Board shall:

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

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

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

(D)(1) collect assessments from all insurers to provide for claims paid

under the plan and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made.

(2) the level of assessments.

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

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

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

SECTION 7. The Board shall:

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

(B) sue or be sued;

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

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

(1) the insurer's proven ability to handle large group accident

and health policies insurance;

(2) the efficiency of the insurer_s claims-paying procedures;

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

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

(C) The administering insurer shall:

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

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

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

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

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

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

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

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

(6) following the close of each calendar year, determine net premiums, re-insurance premiums less administrative expenses allowance, the expense of administration pertaining to the re-insurance operations of the pool, and the incurred losses for the year, and report this information to the Board and to the Commissioner of Insurance.

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

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

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

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

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

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

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

limitation.

SECTION 10. (A) Any assessment may be offset, in an amount equal to the amount of the assessment paid to the pool, against the state corporate income tax or the premium tax payable by that participating insurer for the year in which the assessment is levied or the four years subsequent to that year.

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

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

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

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

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

(2) Any person whose health insurance is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within sixty (60) days after the

involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of the termination of the previous coverage.

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

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

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

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

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

(a) hospital services;

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

(c) drugs requiring a physician's prescription;

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

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

(f) use of radium or other radioactive materials;

(g) oxygen;

(h) anesthetics;

(i) prosthesis, other than dental prosthesis;

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

(k) diagnostic x-rays and laboratory tests;

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

(m) services of a physical therapist;

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

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

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

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

(D) Covered expenses shall not include the following:

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

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

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

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

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

providing the services or articles;

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

(7) any charge for routing physical examinations;

(8) any charge for the services of blood donors and any fee for the failure to replace the first three (3) pints of blood as provided to an eligible person annually; or

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

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

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

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

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

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

SECTION 13. 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. 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. All laws and parts of laws in conflict with this act are hereby repealed.

/s/Rep. Young, et al