State of Arkansas
80th General Assembly
Regular Session, 1995

A Bill

HOUSE BILL 2058

By: Representative Ferguson

For An Act To Be Entitled

"AN ACT TO ENSURE ACCESS TO AFFORDABLE HEALTH INSURANCE; AND FOR OTHER PURPOSES."

Subtitle

"AN ACT TO ENSURE ACCESS TO AFFORDABLE HEALTH INSURANCE."

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

SECTION 1. Title. This act may be cited as the "Patient Bill of Rights Act of 1995."

SECTION 2. Purpose. The General Assembly finds that health insurance coverage should be made available and affordable to all individuals.

SECTION 3. Definitions. As used in this act:

(1) "Covered person" means any person on whose behalf the health care insurer is obligated to pay for or provide health care services.

(2) "Health benefit plan" means the health insurance policy, subscriber agreement, evidence of coverage or administrative services agreement between an employer, association, state, county or municipal agency and the health care insurer which defines the covered services and benefit levels available.

(3) "Health care insurer" means an insurance company issuing disability insurance coverage as defined in Arkansas Code § 23-62-103, a hospital and medical service corporation as defined in Arkansas Code § 23-75-101, a health maintenance organization as defined in Arkansas Code § 23-76-

102, or a company issuing insurance coverage for limited health service.

(4) "Health care provider" means those individuals or entities licensed by the state of Arkansas to provide health care services limited to the following: physicians and surgeons, osteopaths, podiatrists, chiropractors, physical therapists, speech pathologists, audiologists, dentists, optometrists, hospitals, hospital based services, psychologists, licensed professional counselors, respiratory therapists, pharmacists, occupational therapists and long-term care facilities, home health care and hospice care and licensed ambulatory surgery centers.

(5) "Health care services" means services and products provided by a health care provider within the scope of the provider_s license.

(6) "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services. Limited health service shall not include hospital, medical, surgical or emergency services except as such services are provided incident to the limited health services set forth in the preceding sentence.

SECTION 4. Nonrenewal. (a) No health care insurer providing coverage under any health benefit plan to a covered person shall cancel or fail to renew such plan except for any of the following reasons:

(1) nonpayment of required premium;

(2) fraud or misrepresentation on the part of the covered person;

(3) noncompliance with the provisions of the plan.

(b) Nothing in this section shall be deemed to prevent a health care insurer from cancelling or not renewing the coverage of a covered person for fraud or material misrepresentation to the extent allowed by law.

SECTION 5. Conversion privilege. (a) Any person who has been continuously covered for at least ninety (90) days under a health benefit plan and who thereafter loses such coverage by reason of:

(1) termination of employment;

(2) reduction of hours;

(3) divorce;

(4) attainment of any age specified in the health benefit plan;

(5) expiration of any continuation of coverage available as required by state or federal law shall upon written request to the health care insurer, be entitled to receive an individual conversion policy. Such request shall be made within thirty one (31) days of loss of coverage. The premium for any given period shall not exceed one hundred and thirty five percent (135%) of the rate that would have been charged with respect to that person had the person been covered as an employee under the plan during the same period. When the plan under which such person was covered has been cancelled or not renewed, the rates shall be based on the rate which would have been charged to such person had the plan continued in force as determined by the health care insurer in accordance with standard actuarial principles.

(b) Benefits provided under such conversion policy shall not be less than the benefits provided under the health benefit plan. The health care insurer may apply any benefits paid under the health benefit plan against the benefits limits of the conversion policy provided that if it does so, it shall also credit the covered person with any waiting period, deductible and coinsurance to the extent credited under the health benefit plan.

SECTION 6. Portability. Except for underwriting considerations relating to such persons_ health status, no health care insurer shall refuse to accept for coverage, under a health benefit plan any person, who on the date of application for such coverage would be eligible, provided such person has, as of that date, been continuously covered under any employee welfare benefit plan or other health insurance policy or health benefit plan, other than any policy issued by or in connection with any state high risk insurance pool for a period of one year. Nothing herein shall require such covered person as a standard risk under the small employer health benefits plan or greater than those that would have been provided under such prior coverage had it remained in force. For the purpose of this section, a person shall be deemed to be continuously covered for a period of one year if such person is insured at the beginning and end of such period and has not had any lapse in coverage during such period totaling more than thirty one (31) days.

SECTION 7. Premium Rates. (a) The premium rate charged in

connection with a health benefit plan shall be the same for all covered persons with similar case characteristics covered under similar health benefit plans. A health care insurer may adjust the premium charged to a covered person in connection with the health benefit plan based upon the claims experience, the health of persons covered under the health benefit plan and the duration of coverage since the date of issue, provided that the total premium shall not exceed two times the lowest premium charged to a covered person with similar case characteristics.

(b) Subject to the limitations set forth in (a) of this section, the percentage increase in the premium rate charged to covered persons may not exceed the sum of:

(1) the percentage change in the premium rate for covered persons with similar case characteristics as measured between the first day of the calendar year in which the new rates take effect and the first day of the prior calendar year; plus

(2) an adjustment not to exceed fifteen percent (15%) annually based on claims experience, health status or duration of coverage; plus

(3) any adjustment due to changes in the coverage provided or changes in the case characteristics of similar health benefit plans.

SECTION 8. 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 9. 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 10. All laws and parts of laws in conflict with this act are hereby repealed.

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