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

State of Arkansas *As Engrossed: H2/15/01 H2/22/01 S3/2/01*
83rd General Assembly **A Bill**
Regular Session, 2001 HOUSE BILL 1660

By: *Insurance & Commerce- House*

For An Act To Be Entitled

AN ACT TO PROVIDE HEALTH INSURANCE PURCHASING GROUPS FOR ELIGIBLE EMPLOYERS; AND FOR OTHER PURPOSES.

Subtitle

HEALTH INSURANCE PURCHASING GROUP ACT OF 2001.

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

SECTION 1. This act shall be known and cited as the “Small Employer Health Insurance Purchasing Group Act of 2001”.

SECTION 2. Definitions.

For purposes of this act:

(1) "Commissioner" means the Commissioner of the State Insurance Department;

(2) "Eligible employee" means an employee or individual who is a full time employee of an eligible employer and is qualified to enroll in a health benefit plan offered through a HIPG;

(3) "Eligible employer" means an employer employing no more than one hundred (100) eligible employees;

(4) "Employer”, “employee”, and “dependent", unless otherwise defined in this section, shall have the meanings applied to the terms with respect to the coverage under the laws of the state relating to the coverage and the issuer;

(5) "Full time" means employees working at least thirty (30) hours per

week for an eligible employer;

(6) "Health benefits plan" means a group plan, group policy, or group contract for health care services, issued or delivered by a HIPG health carrier, excluding plans, policies, or contracts providing health care benefits or health care services pursuant to Arkansas Constitution, Article 5, §32, the Workers' Compensation Law, the Public Employee Workers' Compensation Act, and the no-fault medical and hospital benefit requirements under Arkansas Code 23-89-202;

(7) "Health insurer" means an insurer licensed to transact group accident and health insurance in this state;

(8) "Health maintenance organization" means a health maintenance organization, as defined in Arkansas Code 23-76-102, which is licensed to transact business in this state as a health maintenance organization under Arkansas Code 23-76-107;

(9) "HIPG" means a health insurance purchasing group meeting the requirements of this act;

(10) "HIPG health carrier" means a health insurer, health maintenance organization, or hospital and medical service organization;

(11) "Hospital and medical service corporation" means a hospital and medical service corporation, as defined in Arkansas Code 23-75-101, which is licensed to transact business in this state as a hospital and medical service corporation under Arkansas Code 23-75-107;

(12) "Large group" means a combination of two (2) or more eligible employers belonging to a HIPG;

(13) "Member" means an individual enrolled for health benefits coverage in a HIPG;

(14) "Purchaser" means an eligible employer that has contracted with a HIPG for the purchase of health benefits coverage;

(15)(A) "State mandated health benefits" means coverages for health care services or benefits, required by state law or state regulations, requiring the reimbursement or utilization related to a specific health illness, injury, or condition of the covered person, or inclusion of a specific category of licensed health care practitioner to be provided to the covered person in a health benefits plan for a health related condition of a covered person. Provided that for the purposes of the options provided by this act, state mandated health benefits which may be excluded in whole or in

part shall not include any health care services or benefits which were mandated by Act 34 of 1971.

(B) "State mandated health benefits" does not mean standard provisions or rights required to be present in a health benefit plan pursuant to state law or state regulations unrelated to a specific health illness, injury or condition of the insured, including but not limited to, those related to continuation of benefits in Arkansas Code 23-86-114, or entitlement to a conversion policy under Arkansas Code 23-86-115; and

(16) "Total eligible employees" means five hundred (500) or more eligible employees.

SECTION 3. HIPG organization requirements.

(a) Each HIPG shall be a nonprofit corporation operated under the direction of a board of directors, which is composed of five (5) representatives of eligible employers.

(b)(1)(A) Each HIPG shall be composed of at least five hundred (500) eligible employees from one (1) or more eligible employers:

(B) However, a HIPG shall have twelve (12) months from the time of formation to reach the level of five hundred (500) eligible employees.

(C) At the time of formation, the HIPG shall have at least one hundred (100) eligible employees.

(2)(A) Upon the failure of a HIPG to maintain the required size restrictions described in subsection (b) of this section, the HIPG shall notify the commissioner in writing that the HIPG does not comply with the size requirements under subsection (b)(1) of this section.

(B) The HIPG may then continue to operate the health benefits plan for its members but shall within sixty (60) calendar days comply with the size requirements of this section, or within a time period as determined by the commissioner.

(C) Upon the failure of the HIPG to maintain size requirements as required under this section, after sixty (60) calendar days, or after the time period determined by the commissioner, the HIPG may then be terminated following notice and hearing before the commissioner.

(c)(1)(A) Subject to the provisions of this act, a HIPG shall permit any eligible employer, which meets the membership requirements of the HIPG, to contract with the HIPG for the purchase of a health benefits plan for its

eligible employees and dependents of those eligible employees.

(B) The HIPG may not vary conditions of eligibility, including premium rates and membership fees, for any employer meeting the membership requirements of the HIPG, nor may it vary conditions of eligibility for any employee to qualify for a HIPG health benefits plan offered to the eligible employer by the HIPG.

(2)(A) A HIPG may not require a contract under subsection (c) of this section between a HIPG and a purchaser to be effective for a period of longer than twelve (12) months.

(B) This shall not be construed to prevent a contract from being extended for additional twelve-month periods or preventing the purchaser from voluntarily electing a contract period of longer than twelve (12) months.

(3)(A) A contract shall provide that the purchaser agrees not to obtain or sponsor a health benefits plan, on behalf of any eligible employees and their dependents, other than through the HIPG.

(B) This shall not be construed to apply to an eligible individual who resides in an area for which no coverage is offered by a HIPG health carrier.

(4)(A)(i) Under rules established to carry out this act, with respect to an eligible employer that has a purchaser contract with a HIPG, individuals who are eligible employees of an eligible employer may enroll for a health benefits plan offered by a HIPG health carrier.

(ii) This may include coverage for dependents of the enrolling employees, if this coverage is offered.

(B) The employees may enroll for health benefits provided through their employer’s contract with a HIPG.

(5) A HIPG shall not deny enrollment as a member to an individual who is an eligible employee, or dependent of an employee qualified to be enrolled based on health status-related factors, except as may be permitted by law.

(6) In the case of members enrolled in a health benefits plan offered by a HIPG health carrier, the HIPG shall provide for an annual open enrollment period of thirty (30) calendar days during which the members may change the coverage option in which the members are enrolled.

(7)(A) Nothing in this subsection (b) shall preclude a HIPG from establishing rules of employee eligibility for enrollment and re-enrollment of

members during the annual open enrollment period under subdivision (c)(6) of this section.

(B) The rules shall be applied consistently to all purchasers and members within the HIPG and shall not be based in any manner on health status-related factors and shall not conflict with sections of this act.

(d)(1) Each HIPG shall annually file with the commissioner:

(A) A description of its plan of operation including each of the products it intends to sell;

(B) A description of its marketing methods and materials;

(C) A description of its membership and disclosure requirements, or other information as required by the commissioner through rules and regulations.

(2) The plan of operation filed with the commissioner by the HIPG pursuant to this subsection shall be deemed approved sixty (60) calendar days after the date of filing, unless additional time is requested by the commissioner to review the plan.

(e) Each HIPG shall be considered a large group for purposes of application of the Arkansas Insurance Code to the activities and health benefit plans of the HIPG, unless stated otherwise in this act.

SECTION 4. HIPG Health Benefits Coverage Requirements.

(a) Each HIPG, in conjunction with a HIPG health carrier, shall make available a health benefits plan in the manner described in this section to all eligible employers and eligible employees at rates, including employer's and employees' share, on a policy or product specific basis which may vary only as permitted under law.

(b) Subject to subsection (c) of this section, a HIPG shall not offer a health benefits plan which unfairly discriminates against eligible employees.

(c) Nothing in this act shall be construed as requiring a HIPG health carrier to provide coverage outside the service area of the insurer or organization.

(d) Each HIPG shall provide a health benefits plan only through contracts with HIPG health carriers and shall not assume insurance risk with respect to the coverage.

(e) Except as provided in this act, the HIPG may develop or offer a

health benefits plan for its members, in whole or in part, not subject to state mandated health benefits, except those required in Arkansas' Health Insurance Portability and Accountability Act of 1997.

(f) The HIPG shall offer at least two (2) types of plans to its members, including one (1) plan providing a choice of deductibles with state health mandated benefits.

(g) The HIPG may also offer a health benefits plan not subject to state mandated health benefits which does not contain standard provisions or rights required to be present in a health benefits plan pursuant to law or regulations unrelated to a specific health illness, injury, or condition of the insured, for the provisions as may be determined by rules and regulations of the commissioner.

(h)(1) Every health benefits plan offered through a HIPG shall:

(A) Be underwritten by a HIPG health carrier that:

(i) Is licensed or otherwise regulated under state law;

(ii) Meets all applicable state standards relating to consumer protection, including, but not limited to, state solvency and market conduct; and

(iii) Offers the coverage under a contract with the HIPG;

(B) Be approved or otherwise permitted to be offered under law;

(C) Provide full portability of creditable coverage for individuals who remain members of the same HIPG notwithstanding that they change the eligible employer through which they are members; and

(D) Comply with the provisions of the Arkansas Insurance Code in their sales and solicitation of insurance including, but not limited to, the Trade Practices Act, and Arkansas Code 23-64-201 and 23-64-102(1) requirements that all insurance must be sold by an agent licensed by the State Insurance Department.

(2)(A) Any agent referenced in subdivision (h)(1)(D) of this section shall be required to obtain at least two (2) hours of continuing education on a HIPG or the plans the HIPG sponsors each year, or both.

(B) This requirement shall be considered as part of the continuing education requirements provided in Arkansas Code 23-64-301 and

shall not preempt or conflict with the provision.

(i) A HIPG shall be exempt from the requirements of Arkansas Code 23-86-201 - 23-86-209.

(j) Nothing in this act shall be construed as precluding a HIPG health carrier from offering a health benefits plan through a HIPG by establishing premium discounts for members, or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, so long as the programs are agreed to in advance by the HIPG and comply with all other provisions of this act and do not discriminate among similarly situated members.

SECTION 5. Notice and requirement of eligible employee to reject a state mandated health benefits plan in writing.

(a)(1) In each sale of a health benefits plan to a proposed eligible employer through a HIPG, in which the HIPG offers an option to an eligible employer to obtain a health benefits plan which, either in whole or in part, does not provide state mandated health benefits, or does not contain standard provisions as may be determined by rules and regulations of the commissioner, the HIPG shall provide to the proposed eligible employee a written notice as required in subsection (b) of this section and shall obtain from the proposed eligible employee a rejection in writing that the eligible employee has rejected a health benefits plan providing state mandated health benefits, or standard provisions.

(2) The signed rejection required in subdivision (a)(1) shall also include a listing of the standard provisions and state mandated health benefits rejected by the insured or eligible employee.

(b) The written notice required in subsection (a) shall state in the written application or enrollment form to the eligible employee for the health benefits plan the following language in bold type:

"You have the option to select an alternative health insurance policy or health plan which is not subject to all of the state mandated health benefits, or standard health insurance policy or contract provisions, normally required in insurance policies or contracts in Arkansas. Some examples of state mandated health benefits which may be rejected by you include maternity and newborn coverage, in-vitro fertilization, diabetes and pediatric preventative care. In addition, you may be allowed to reject standard insurance contract

provisions and rights required by state law to be present in health benefits plans. This alternative health insurance policy or contract may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits coverages than those normally imposed on health insurance policies in Arkansas."

(c) Upon the failure to provide the written notice or rejection as required in this section, the proposed eligible employee is deemed to have selected a health benefits plan subject to all applicable state mandated health benefits and services and standard provisions and rights required by state law on health benefits plans.

SECTION 6. HIPG administrative services to members.

(a)(1) Each HIPG may provide administrative services for its members.

(2) The services may include, but are not limited to, accounting, billing, enrollment information, and employee coverage status reports.

(b) The HIPG may delegate or contract its billing and other administrative duties to a third party administrator as defined under Arkansas Code 23-92-201 in compliance with the Arkansas Insurance Code.

(c) Nothing in this subsection shall be construed as preventing a HIPG from serving as an administrative service organization to any entity.

(d)(1) Each HIPG shall collect and disseminate or arrange for the collection and dissemination of consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HIPG to its members.

(2) The information shall be defined by the HIPG and shall be in a manner appropriate to the type of coverage offered.

(3) To the extent practicable, the information shall include information on provider performance, locations, and hours of operation of providers, outcomes, and similar matters.

(4) Nothing in this section shall be construed as preventing the dissemination of the information or other information by the HIPG or by the health care insurer, health maintenance organization, or organization through electronic or other means.

(e) The contract between a HIPG and a HIPG health carrier shall provide that the HIPG may collect premiums on behalf of the issuer for coverage, less a predetermined administrative charge negotiated by the HIPG and the issuer.

SECTION 7. Filing and form filing requirements.

Each HIPG shall file forms as may be described by rules and regulations of the commissioner.

SECTION 8. Prevention of conflicts of interest.

(a) A member of a board of directors of a HIPG shall not serve as an employee or paid consultant to the HIPG, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

(b) An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HIPG or as an employee of the HIPG, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in an organization from whom the HIPG receives contributions, grants, or other funds not connected with a contract for coverage through the HIPG.

(c)(1) An individual who is serving on a board of directors of a HIPG as a representative described in subsection (b) of this section shall not be employed by or affiliated with a HIPG health carrier.

(2) For purposes of subdivision (c)(1)(A) of this section, the term "affiliated" does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a HIPG health carrier.

SECTION 9. HIPG operations and coordination.

(a) Nothing in this act shall be construed as preventing one (1) or more HIPG serving different areas, whether or not contiguous, from providing for some or all of the following through a single administrative organization or otherwise:

(1) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HIPG; or

(2) Providing for crediting of deductibles and other cost-sharing for individuals who are provided a health benefits plan through the HIPG or affiliated HIPG after:

(A) A change of eligible employers through which the coverage is provided; or

(B) A change in place of employment to an area not served

by the previous HIPG.

(b) Nothing in this act shall be construed as precluding a HIPG from providing for adjustments in amounts distributed among the HIPG health carrier offering a health benefits plan through the HIPG, based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

(c) Nothing in this act shall be construed as precluding a HIPG from establishing minimum participation and contribution rules for eligible employers that apply to become purchasers in the HIPG, so long as the rules are applied uniformly for all HIPG health carriers.

SECTION 10. Premium rates.

(a) The HIPG may determine what rating characteristics it will allow in the health benefit plan including, but not limited to, age, sex, industry, geography, or health.

(b) If health is used as a rating characteristic, then the rates for the size groups two (2) through twenty-five (25) will be subject to the small group rating law as required in Arkansas Code 23-86-201 - 23-86-209 but may be considered separate from any small groups sold outside the HIPG.

SECTION 11. Rules and regulations.

The commissioner may promulgate regulations necessary to implement the provisions of this act.

SECTION 12. HIPG health carrier market.

No HIPG health carrier shall be required to offer HIPG health benefits plans, or health benefits plans not subject to state mandated health benefits, to non-HIPG organizations, associations, or employer groups, including but not limited to the small employer health insurance group marketplace in this state.

/s/ Insurance & Commerce- House