Arkansas
Insurance Department

Arkansas Health Insurance Portability and Accountability Act (HIPAA)
(Act 997 of 1997)

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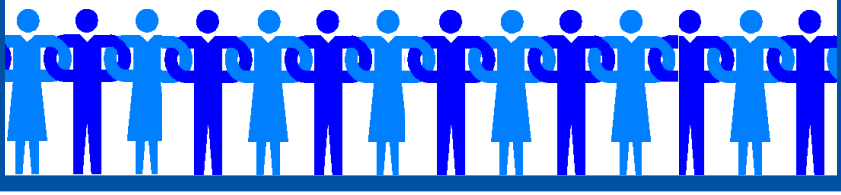

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The Arkansas Insurance Department takes very seriously its mission of "consumer protection." We believe part of that mission is carried out when consumers are equipped to make informed decisions. We believe informed decisions are made through the accumulation and evaluation of relevant information.

This booklet is designed to provide basic information about Arkansas's Health Insurance Portability and Accountability Act (HIPAA). Its purpose is to help you understand the State's HIPAA laws and how those laws affect your coverage.

If you have questions or need additional information, please contact our Consumer Services Division at:

Phone: (501) 371-2640; 1-800-852-5494
Fax: (501) 371-2749
Email: insurance.comsumers@arkansas.gov
Web site: www.insurance.arkansas.gov

Mission Statement

The purpose of the State Insurance Department is to serve and protect the public interest by the equitable enforcement of the state's laws and regulations affecting the insurance industry.

The primary mission of the State Insurance Department shall be consumer protection through insurer solvency and market conduct regulation, and fraud prosecution and deterrence.

SUBJECT

Arkansas Act 997 of 1997, the Arkansas Health Insurance Portability and Accountability Act of 1997, codified as new Arkansas Code Ann. ("ACA") § 23-86-301, et seq.

PURPOSE

This bulletin is to provide a summary about the new Arkansas companion law to the Federal Health Insurance Portability and Accountability Act of 1996 (also know as HIPAA, Kennedy-Kassenbaum, KK). The full text of Act 997 of 1997 may be obtained from the Arkansas Secretary of State, State Capitol Building, State Capitol Grounds, Little Rock, AR 72201 or 501-682-1010.

RELATED LAWS

1. Arkansas Act 292 of 1997, which is the 1997 update of the Arkansas Comprehensive Health Insurance Pool Act (CHIPS). This provides that the state risk pool is the Arkansas individual alternative mechanism for those losing group coverage with no other alternative. See ACA §§ 23-79-501, et seq., as amended.

2. Arkansas Act 517 of 1997, the update of the Arkansas long term care laws to conform ACA § 23-96-101 et seq. to HIPAA, particularly regarding qualified products for tax deductibility of premiums.

3. Arkansas Act 1000 of 1997, the Department's Omnibus Act:

   A. Section 17 amends Arkansas law and cash fund exemptions as to new CHIPS act and others.

   B. Sections 18 through 23 conform the Arkansas Small Employers Group Health Act, ACA § 23-86-201 et seq., to HIPAA. The small group size of 1 to 25 was retained for rating purposes only.

   C. Sections 24 and 25 provide later amendments to Act 292 of 1997, the new CHIPS Act.

SUMMARY DESCRIPTION OF ACT 997 (ARKANSAS' HIPAA)

◆ ***What it does not do:***

- Does not mandate insurance.
- Does not mandate the level of benefits.
- Does not mandate the level of premiums.

- ***Portability***

This is to combat "job lock".

It applies to groups of 2 and larger.

It means that if you have group coverage, you are guaranteed health coverage for life as long as you can pay the premiums.

It does not apply to changes from individual to individual.

It limits preexisting conditions to a 6 month look back and a 12 month look forward (18 months if you are a late enrollee).

The preexisting clause cannot be applied to certain categories of people: pregnancy, newborns, newly adopted.

Credit against the preexisting clause can be gained by having prior creditable coverage of up to 12 months with no break in coverage of over 63 days.

- ***Guaranteed Renewable***

This applies to insurance carriers.

Your coverage is guaranteed renewable for life if you are an individual, and for as long as your employer wants to keep the coverage if it is a group employer case with only the following exceptions:

1. The carrier can nonrenew the product if you do not pay premiums.

2. The carrier can nonrenew the product for fraud.

3. The carrier can terminate an entire market (for example all small group business in the State of Arkansas), but then the carrier cannot write in that market for 5 years.

- ***Guaranteed Issue***

1. Each health insurer selling in the small group market (2 to 50 employees) must accept every small employer, including every eligible individual.

2. The carrier must make available to each small employer every product that is available to any other small employer, which includes deductibles and amount limits.

3. The carrier may vary participation requirements and employer contribution by size of the group, but not based on health status.

4. If an individual joins a group that has insurance, and the individual is an eligible employee, then that insurance is guaranteed issue to that individual, but preexisting clauses could be imposed up to 12 months unless there is creditable coverage.

- ***Miscellaneous***

1. The HIPAA law and the accompanying regulations are hundreds of pages - this is just a brief summary.

2. HIPAA provides for certain maternity benefits (48-hour hospital stay after a normal birth and a 96-hour hospital stay after a caesarian birth) which, unfortunately, primarily raise costs.

3. Mental health parity requiring amount limits to be the same for mental health care as for medical/surgical benefits. This does not have to be included if the costs are shown to exceed 1 percent. In the State of Arkansas in virtually all cases, the cost will be more than provided for in the Bill. Insurance companies can still include the benefit, but again the problem is cost.

4. Medical care savings accounts were provided in the Bill on a test basis. This provides that the policyholder gets a high deductible policy and the premium savings are put in a tax preferred account for the individual to control and use in the purchase of healthcare benefits below the deductible amount. It puts health care cost control in the hands of the consumer and purchaser of the health care benefit. This is the most positive aspect of the Bill outside of the limitations imposed by Congress.

IMPACT OF ARKANSAS' HIPAA ON THE INDIVIDUAL

- ***Requirements Prior to an Employer's First Plan Anniversary on or After July 1, 1997:***

On or after June 1, 1997, the employer or the insurance carrier must provide terminating employees with certificates of coverage.

- ***Requirements on or after an employer's first plan anniversary on or after July 1, 1997:***

1. Current employees who are eligible (for example, not part time employees) on this new first plan anniversary.

    a. Anyone currently covered that is subject to a preexisting clause can now only have that clause applied for a maximum of 12 months from the time they were first covered. So, if your employer's plan has already covered the employee for 12 months, the employee would no longer be subject to any preexisting clause.

    b. If an eligible employee was declined, they can now reapply and will be covered subject only to a preexisting condition clause of 12 months, less credit for up to 12 months of any prior coverage that did not have a 63-day break.

    c. Any employee who declined coverage because they had coverage elsewhere (for example, a dependent on a spouse's

policy) can voluntarily drop that coverage and now be covered. They would be subject to a 12-month preexisting clause, less the amount of time they were covered by any other insurance, as shown by a certificate of coverage from the appropriate carrier(s) and/or employer(s).

d. Anyone who simply declined coverage (not because they had other coverage) may now apply if, in fact, the employer accepts late enrollees. If an employer accepts late enrollees, they can take the employee subject to the 18-month preexisting clause application applicable to late enrollees. This can even apply as a waiting period, which would count against the preexisting condition clause, during which period the employee would pay no premiums but have no coverage. The employee then would have full coverage with no preexisting condition clause applied at the end of the 18-month waiting period/preexisting period.

2. New eligible employees hired after an employer's plan anniversary that occurs on or after July 1, 1997.

a. The employer must cover all eligible employees.

b. The maximum preexisting clause that can be applied is for 12 months, less any creditable coverage.

c. The employer may impose a waiting period (it must be the same for all new employees) during which time the employee will have no coverage, but the waiting period is not considered a break in coverage and will count as credit against the preexisting condition clause.

d. Each individual is guaranteed renewable. That means that neither the employer nor the insurance carrier can nonrenew a given individual solely for health reasons, or any other reason, unless they are no longer an eligible employee (for example, they are no longer a full time employee).

e. There can be no difference in rates for individuals based solely on health status. All members of the group may be charged higher rates because of the overall health status of the entire group.

f. An insurance carrier may still require reasonable medical information on employees that are to be covered, in order that the carrier may set an appropriate overall group rate.

3. What the group insurance carrier must do.

The policy is guaranteed renewable as long as you meet:

☑ any employee size requirements;
☑ the minimum participation requirements;
☑ the minimum percentage contribution required of the

employer;

- ☑ pay the premiums; and
- ☑ no fraud was committed in the obtaining of the group policy.

Still, an insurance carrier can nonrenew the policy if, in fact, they nonrenew all the policies they have in the State of Arkansas in that market (small group, large group, individual, association). That is, they leave the entire market, and they leave it for a period of 5 years.

◆ ***The impact of some of these requirements:***

1. Preexisting condition clause — This is the maximum period, which is 12 months (18 months for a late enrollee), that coverage can be excluded for any illness or accident that occurred before the enrollment date. Anything that occurred after that date would be covered once coverage began. To determine if an illness/accident is preexisting, the insurer can look at only the 6 months prior to the enrollment date to see if the individual received any treatment or diagnosis for such illness/accident.

2. If the employer's coverage terminates, or an individual changes employers and there is no insurance (or no insurance for previously covered dependents) or an individual just quits working, then the State risk pool (CHIPS) may be the only option. All other possibilities of coverage must be exhausted (e.g. COBRA, continuation of small group coverage, Medicaid) and the individual must have 18 months of continuous group coverage (no break in coverage of 63 days or more). Note that CHIPS is available to anyone who cannot get other coverage, but there is a 6-month preexisting condition clause for anyone not meeting the above requirement.

IMPACT OF ARKANSAS' HIPAA ON THE SMALL EMPLOYER

◆ ***Requirements prior to your first plan anniversary on or after July 1, 1997:***

On or after June 1, 1997, you or your carrier must provide terminating employees with certificates of coverage.

◆ ***Requirements on or after your first plan anniversary on or after July 1, 1997:***

1. Current employees who are eligible (for example, not part time employees) on this new first plan anniversary.

   a. Anyone currently covered that is subject to a preexisting clause can now only have that clause applied for a maximum of 12 months from the time they were first covered. So, if your plan has already covered them for 12 months, they are no longer subject to any preexisting clause.

   b. If any of your eligible employees were declined, they can now reapply and will be covered subject only to a preexisting condition clause of 12 months less credit for up to 12 months

of any prior coverage that did not have a 63 day break.

c. Any employee who declined your coverage because they had coverage elsewhere (for example, a dependent on a spouse's policy) can voluntarily drop that coverage and now be covered by your plan. They would be subject to a 12-month pre-existing clause, less the amount of time they were covered by any other insurance, as shown by a certificate of coverage from the appropriate carrier(s) and/or employer(s).

d. Anyone who simply declined your coverage (not because they had other coverage) may now apply if, in fact, you accept late enrollees. If you accept late enrollees, you can take them subject to the 18-month preexisting clause application applicable to late enrollees. You can even apply this as a waiting period, which would count against the preexisting condition clause, during which period they would pay no premiums but have no coverage. They then would have full coverage with no preexisting condition clause applied at the end of the 18-month waiting period/preexisting period.

2. New eligible employees hired after your plan anniversary that occurs on or after July 1, 1997.

a. You must cover all eligible employees.

b. The maximum preexisting clause that you can apply is for 12 months, less any creditable coverage.

c. You may impose a waiting period (it must be the same for all new employees) during which time they will have no coverage, but the waiting period is not considered a break in coverage and will count as credit against their preexisting condition clause.

d. Each individual is guaranteed renewable. That means that neither you or your carrier can nonrenew a given individual solely for health reasons, or any other reason, unless they are no longer an eligible employee (for example, they are no longer a full time employee).

e. You can charge no difference in rates for individuals based solely on health status. All members of your group may be charged higher rates because of the overall health status of the entire group.

f. An insurance carrier may still require you to comply with supplying reasonable medical information on only your employees that are to be covered, in order that the carrier may set an appropriate overall group rate.

3. What your small group insurance carrier must do for you as a small employer.

a. Your policy is guaranteed renewable to you as long as you meet:

- ☑ an employee size of 2 to 50;
- ☑ the minimum participation requirements;
- ☑ the minimum percentage contribution required of the employer;
- ☑ pay the premiums; and
- ☑ you committed no fraud in the obtaining of your group policy.

Still, an insurance carrier can nonrenew your policy if, in fact, they nonrenew all the small employer policies that they have in the State of Arkansas. That is, they leave the entire market and they leave it for a period of 5 years.

b. An insurance carrier who issues policies in the small group market guarantees that if you meet participation and contribution requirements, they will issue you a small group policy giving you the choice of all the benefits, deductible and co-pay that they offer in the small group market. This assures you that if your policy is nonrenewed, you can get coverage from another carrier, or change carriers anytime you want to. What is not guaranteed to you, is the amount of premiums that may be charged to your small group.

c. If your small group is in the 26 to 50 size range, the rates can be established by the carrier specific to your group. The carrier cannot charge an individual a different rate solely based on health status. If your group is less healthy, the entire group will be charged higher premiums.

d. If the size of your group is in the 2 to 25 range, there is a limit on the range that insurance carriers can charge strictly for health status. The maximum increase in rates solely for health reasons is 167 percent of their most competitive rate. The carrier can set its competitive rate where it chooses, so this still does not assure you of what the rate will be, but only the maximum amount that you can be surcharged for your group's health status.

QUESTIONS AND ANSWERS

◆ ***Where do I get answers to my questions?***

We recommend the following document *"Questions & Answers: Recent Changes in Health Care Law"* produced by the U.S. Department of Labor. A free copy can be obtained by calling 1-800-998-7542 and requesting this document. All our questions and answers below attempt not to duplicate this document and therefore presume an awareness of this document.

Questions about individual health insurance, fully insured group insurance, association insurance, and multiple employer trusts can be directed to the Arkansas

Insurance Department at 1 Commerce Way, Suite 102, Little Rock, AR 72202-2087, telephone number 1-501-371-2600.

Questions about ERISA and self-funded plans can be directed to the U.S. Department of Labor, Pension and Welfare Benefits Administration field office for Arkansas: Dallas Area Office, Room 707, 525 Griffin Street, Dallas, TX 75202, telephone number 1-214-767-6831.

Can I rely on the answers below? The Federal government has not come out with final regulations yet. Therefore, what is given below is guidance on how the Arkansas Insurance Department intends to enforce HIPAA. We intend this to help companies show good faith in complying with HIPAA, but we must all realize that as the Federal government produces regulations, the answers to the questions below could change. (The numbers next to each question below, if shown, refer to the page numbers in the document *"Questions and Answers: Recent Changes in Health Care Law"* by the U.S. Department of Labor referred to above.)

◆ ***Implementation Dates (22, 34, 56)***

Q. ***When will the HIPAA requirements apply to me?***

A. For all new plans sold, HIPAA applies effective July 1, 1997. Certificates of Creditable Coverage must already be provided dating back to as early as mid-1996. Small and large group plans are subject to HIPAA on the first anniversary of their plan on or after July 1, 1997.

◆ ***General Group Rules***

Q. ***Can a group health plan offer discounts or rebates for wellness programs?***

A. A group health plan can offer discounts or rebates for participation in a wellness program, but it cannot offer discounts or rebates for health results. For example, the plan cannot reduce premiums to an individual for the result of getting lower blood pressure by participating in a wellness program. Different rates can be charged for smokers versus nonsmokers and for industry.

Q. ***Can a group insurance carrier require life insurance with the sale of health insurance.***

A. Yes -- but in the large group market the declination of life insurance for an individual cannot be used as a basis to refuse the individual's health insurance. If the individual is an eligible employee and the employer offers a group health plan, the employee must be offered the group health plan. An employer could require applying for both life and health, and paying for the life if approved in order to get the health, if this same rule applied to all eligibles.

In the small group market the "requirement" of life insurance coverage would make the life insurance guaranteed issue. A carrier could require applying for both life and health with 1) a life rejection not prohibiting the issuance of health coverage or 2) the life acceptance requiring the life insurance to be paid for to keep the health insurance. The rules

must be the same for all eligibles. Note that the healthy would pay more (because of the life insurance).

Q. ***Are there any rating limitations at all in Arkansas?***

A. It varies by market:

1. There are no rating limitations in the large group market which is a group plan of over 50 employees.

2. There are no rating limitations in the small group market of 26 to 50 employees.

3. In the small group market of 1 to 25 Arkansas does not limit the rates, but limits the range or difference that can exist in the rates. (See ACA §§ 23-86-201 to 209). The maximum difference between the lowest and highest rates for similarly situated individuals is +/- 25 percent from an index rate. The maximum difference between classes is 20 percent (there is no maximum class difference between underwritten and guaranteed issue business). The maximum permissible rate increase each year is the change in the index rate plus 15 percent, subject to falling within the permissible range. Certifications of compliance with supporting data must be filed with the Arkansas Insurance Department annually by the small group insurance carriers. We realize that companies could have a guaranteed issue block which would be all new business, a closed block that is fully underwritten, and a current open block that was fully underwritten and is now gradually becoming guaranteed issue. We expect the company in its certification to address the consistency in pricing of this block with the other two blocks.

4. All individual rates must be filed and approved in the State of Arkansas and meet the required loss ratio requirements.

Q. ***Is there an "industry" rating limit?***

A. No -- since "industries" can be rated appropriately, there should be a market (not like health in 1-25 which has caps.)

Q. ***If I am an individual with individual insurance, can I voluntarily stop paying the premiums on my individual insurance and expect my group employer's insurance plan to cover me?***

A. The answer is different depending on the circumstances:

1. If you are joining your employer's group plan on your first eligible enrollment date, then you will be fully covered and receive credit against your employer's preexisting condition clause (maximum of 12 months) for as long as you had your individual coverage. You need to make sure that your employer's group plan is already subject to HIPAA requirements (i.e. has had a plan anniversary on July 1, 1997

or later).

2. If you are an individual already working for a group employer with an insurance plan, you may voluntarily drop your individual health insurance and be eligible for group coverage on your group's first plan anniversary on or after July 1, 1997, and you would receive credit against the group's preexisting condition clause for as long as you had your individual health insurance or any other coverage prior to that, provided you did not have a 63 day break in coverage.

3. If you are an individual working for a group employer with an insurance plan and your individual insurance is involuntarily canceled by your insurance carrier (except for fraud or nonpayment of premiums), then you are entitled to a special enrollment period with your employer; and you will receive credit against your employer's preexisting clause for as much coverage as you had, up to 12 months where you did not have a 63 day break in coverage (25).

4. If you are an individual who wishes to be covered by your group employer's health plan after your initial enrollment date and after your group health plan enrollment date, where the plan was first subject to these rules, and you intend voluntarily to stop paying your individual health premiums, then you are eligible only as a late enrollee. You will need to see if your plan accepts late enrollees and if so, when such open enrollment dates will occur. As a late enrollee, you will be subject to any waiting periods and preexisting conditions that the plan would apply.

Q. ***Do group products need to be filed with the Arkansas Insurance Department?***

A. Yes -- all group products, policies and certificates must be filed with the Arkansas Insurance Department. If a group policy is to be used in another state, then only the certificate has to be filed in the State of Arkansas (See ACA § 23-79-109).

Q. ***Are self-insured plans, both ERISA and non-ERISA, subject to HIPAA?***

A. Yes -- and that includes the requirement that such plans must provide certificates of coverage as required by the law.

Q. ***Can a new group carrier or group health plan apply rules that in effect apply a preexisting condition clause to me? (5-13)***

A. Upon replacement, a new group health plan or a new group carrier cannot use utilization review or prior authorization requirements to act as preexisting exclusion periods. The maximum preexisting condition period that can be applied in groups 2 or more is a 6 month look back and a 12 month look forward (this is 18 months for late enrollee). There is no preexisting condition period allowed for pregnancy, newborns, and

newly adopted children.

Q. ***Are there any special rules if I get married, have a child, or adopt a child? (25)***

A. There is a special enrollment period in the event of any of the above events. This means that you can immediately enroll in your group employer's insurance plan, but you are subject to the 12 month preexisting condition clause, less credit for any creditable coverage.

Q. ***Must a group carrier take a late enrollee? (6)***

A. No -- a group health plan does not have to take a late enrollee. But if the group health plan does take the late enrollee, the maximum period that the plan can apply a preexisting clause is 18 months. They can apply this as a waiting period during which time there would be no coverage. If the group health plan uses a preexisting clause and not a waiting period, the plan must give credit against the preexisting condition clause for any prior coverage.

Q. ***Can an employer require an "actively- at-work" rule in order for the insurance to become effective?***

A. Yes -- provided the "actively-at-work" rule is applicable to all eligible employees regardless of the reason that they are not actively at work.

Q. ***What constitutes an employee to determine group size and who is eligible?***

A. "Small employer" or "large employer" shall be determined based on the number of "eligible employes." In determining the number of "eligible employees," companies that are affiliated companies, or that are eligible to file a combined tax return, shall be considered one employer. An insurance carrier shall define an "eligible employee" to mean an employee who works on a full time basis with a work week of thirty (30) or more hours. At the insurance carrier's option, the carrier may require fewer than thirty (30) hours per week providing it does so uniformly for employers in either the large or small group market. At the employer's sole discretion the term eligible employee may include only employees who work more than thirty (30) hours per week provided the same criteria applies to all 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 a employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis or who works less than thirty (30) hours per week. Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation requirements.

Q. ***If a health plan has no "active" employees, is it then subject only to the individual requirements of HIPAA (e.g. a group health plan for retirees only or an association)?***

A. No -- "Active" employees is not a necessary requirement for being subject to all of HIPAA's group requirements.

Q. ***Would benefits reinsured or a wrap around plan on a basic major medical policy be subject to the Acts?***

A. Yes.

Q. ***If I'm currently employed and have been denied coverage or am currently subject to a preexisting clause, will the new Act do anything for me? (5-13)***

A. If your employer provides a group health plan, on the plan's first anniversary on or after July 1, 1997, you are eligible to enroll if, in fact, you were denied coverage before; and you will not be considered a late enrollee. You will be subject to a preexisting condition clause of 12 months, less any creditable coverage. If you are currently enrolled but subject to a preexisting condition clause, on the enrollment date on or after the first anniversary of your plan, on or after July 1, 1997, you will be subject to at most a 12 month preexisting condition clause, less credit for all creditable coverage prior to that date. The plan cannot delay your enrollment or eligibility based on health status.

Q. ***Can a carrier terminate a child at a certain age on a family policy?***

A. Yes -- provided alternate coverage is offered at standard rates. If the carrier sells only group then it cannot terminate coverage completely until 18 full months of coverage so the child is federally eligible for the Arkansas CHIPS plan.

Q. ***Can a carrier vary commissions, incentives, bonuses by health status or case characteristics?***

A. Yes -- for individual or large group. For small group (2-50) commissions, incentives and bonuses, but not maintaining a contract, can be varied only on a separately identified substandard health or industry premium. No other variations for small group case characteristics are permitted.

Q. ***Can the spouse of an employee keep their own health insurance coverage at their place of employment and then can the employer of the employee refuse to cover the spouse, even though the employer of the employee offers family coverage?***

A. Yes -- the employer can refuse to provide duplicate coverage, but the coverage must be offered so the employee and spouse have the option of which coverage they want for the spouse. Of course, the employer can allow duplicate coverage, but a coordination of benefits clause is recommended.

◆ ***Special Considerations for Small Groups***

Q. ***How do I calculate the number of employees to determine if I am a small employer?***

A. If over the prior calendar year you employed an average of at least 2 but not more than 50 employees on the business days in that calendar year, and you employ at least 2 employees on the first day of the plan year, you are a small employer.

Q. ***In the small group market (2-50), can an insurer sell to only certain size groups, or can an insurer offer different plans or networks or benefits or deductibles based on group size or industry?***

A. No -- if an insurer is in the small group market it must offer all of its plans on a guaranteed issue basis to all small employers seeking coverage; at which time, the small employer may choose which plan including deductible, copay, and benefits. All of these must be available to each small employer. In addition, whatever benefits or plan that the small employer picks, all of those must be available to each eligible individual on the same basis with no difference in cost to the individual that is based solely on health status. Note that Federal law mandates maternity coverage for groups of 15 and over which treats maternity like any other illness. We do not construe this to mean that in groups of 2 to 14 that maternity must be covered or for that matter even offered. This is because maternity is a mandated benefit on a particular size of group. For example, if maternity is offered at lives below 14, a participation requirement could not be imposed that would require at least 5 family policies with maternity. This would make the offering not available in the 2 to 4 life market, which is not permitted, since, outside of the mandate, every benefit, deductible, copay, etc. must be made available to all size groups. As a further example, a drug card could not be available only to groups of a certain size and larger, but not to smaller groups. This does not prohibit a requirement for a percentage of participation in the entire plan based on size of employer, and also a requirement for an employer contribution at a certain level based on size of employer. The participation and employer contribution requirements cannot vary by benefit, deductible, copay, health status, industry, etc.

Q. ***Can premiums vary between similarly situated groups?***

A. Yes -- if it is a group of 1 to 25, it is subject to the Arkansas Small Group Rating law of +/- 25 percent from the index rate, but an individual in the group cannot be charged more than another in the group solely because of health status. A group larger than 25 can be charged the appropriate premium for the group recognizing the health status in total of the group, but, an individual in the group cannot be charged a different premium based only on health status. If the group is larger than 50 employees, the insurance carrier can set the rate appropriate for the group; again, not charging individuals different rates based solely on health status, but the insurance carrier in this case can refuse to insure the group at all.

Q. ***Can an insurer have more than one class under the Arkansas Small Group Rating law after Act 997 (HIPAA) is effective?***

A. Yes -- the intent is that classes be limited, but, for example, underwritten business (which can only be a closed block of business written prior to July 1, 1997 or the one life self-employed on or after July 1, 1997)

can be a separate class from a block that is entirely guaranteed issue. In addition, there is no limit on the percentage difference between an underwritten class and a guaranteed issue class. We can envision a class of business previously underwritten that now must take guaranteed issue new entrants and would in effect be a class somewhere in between a fully underwritten block and a fully guaranteed issue block. We would expect in the company's annual filing with the State to address very specifically how it will handle this in the interim period, until the open block becomes almost entirely guaranteed issue. We can also see another class being established between direct business and agent solicited business, but in the future both of these classes would be guaranteed issue and subject to the maximum class difference of 20 percent.

Q. ***Can a small employer drop coverage and immediately get guaranteed issue for better coverage (for example, a much lower deductible) if, in fact, such coverage is available from any other carrier?***

A. Yes -- but the small employer who voluntarily stops paying premiums to insurance company A may be barred by insurance company A from applying again to that company for some limited period of time, provided company A applies this same rule to all small employers who voluntarily stop paying premiums.

Q. ***If a small employer changes insurance carriers, which carrier is responsible for which benefits?***

A. If on the date the old coverage terminates there is an individual in the hospital, the prior carrier must continue to pay for that hospital coverage until the first date that the individual leaves the hospital. All other claims with a date of service on or after the effective date of the new coverage would be paid by the new carrier. This, of course, refers only to benefits provided under the policy provided by the new carrier. (See ACA §§ 23-86-116 for further details.)

Q. ***Can different premiums be charged in the small group market based on different participation and/or contribution rates?***

A. Yes.

Q. ***May small employer carriers apply different participation and employer contribution requirements by group size?***

A. Yes

Q. ***Must a small group insurance carrier issue a small group policy to a small group employer who already has coverage, or must a small group carrier cover an individual who works for a small employer who already has individual coverage?***

A. No -- guaranteed issue does not require the issuance of duplicative comprehensive major medical coverage. The rules applicable to this situation are up to the group insurance carrier, provided the carrier does not vary these rules by health status. The carrier is also entitled to include a coordination of benefits clause in its policy.

Q. ***If an insurer makes a group quote which is turned down by the potential policyholder and at a later date the policyholder reapplies, can the insurer offer a new and revised quote?***

A. Yes.

Q. ***Can a small group carrier require the filling out of a medical application before coverage is granted?***

A. Yes -- the carrier can make such a requirement because such information may be used to determine the overall rating of the group, but it cannot be used to determine an individual's specific rating or eligibility for coverage. This information is strictly for rating purposes and cannot be unreasonable in nature. We would consider as unreasonable, requests that ask for medical information on those not to be covered (the information can be obtained at the time that they are to become covered), that ask for all medical records for the entire life of anyone to be insured, or that ask broadly phrased open-ended questions.

Q. ***Can an insurer ask health questions on employees and dependents not covered in the small group market?***

A. No.

Q. ***Can a small group insurer treat a husband and wife as eligible only for a family policy and not as a small employer?***

A. This is up to the small group carrier, but it must treat all situations the same. In other words, some husband and wife combinations cannot be treated as eligible for a family policy subject to full underwriting and some other husband and wife combinations treated as small employers. Note that the Department of Labor regulations for Title 1 of ERISA say that an individual and a spouse are deemed not to be an employee with respect to a trade or business wholly owned by the individual or by the individual and the spouse.

Q. ***Are there any special disclosure requirements that benefit individuals? (31-33)***

A. Yes -- Act 997 (Arkansas HIPAA) has special requirements for groups of 2 to 50. Small employers are entitled to special disclosure about benefits, limitations, rates, rate changes, renewability, and the application of preexisting conditions. HIPAA has special requirements for ERISA groups. There are no special disclosure requirements for non-ERISA groups larger than 50. Individual policies are subject to a separate Arkansas law for disclosure.

Q. ***Can a small group insurer pay different commissions or otherwise limit an agent's contract if an agent submits small employer groups that are not healthy?***

A. Agents and carriers shall not take any steps to discourage small

employers or individuals working for such small employers from filing an application for coverage. Therefore, a small insurance carrier cannot alter an agent's contract or alter an agent's commissions based on the health status of any small employer group which is submitted. If there is a separately stated substandard premium, we will allow a separate commission arrangement (agreed to between the company and the agent) applicable only to the substandard premium. We will also allow separate commission arrangements, based on industry, that are agreed to in contract form between the agent and the company. These commissions can only vary by industry, and not by health status. Any violation of this instruction will be considered by Arkansas to be an unfair trade practice to be pursued and penalized accordingly.

- ***HMO Affiliation Periods***

Q. ***Can an HMO vary an affiliation period by group?***

A. Yes -- but it is subject to the maximum in the law, which is 2 months, or 3 months for late enrollees, and the variation cannot be based on health status.

- ***Associations and MEWAs***

Q. ***What is the difference between a bona fide association and one that is not (e.g. a discretionary or voluntary association)***

A. In summary, a bona fide association is an association that must be in existence for at least five (5) years, be for purposes other than insurance, does not condition association membership on health status, offers coverage to all members regardless of health status and offers health insurance only to members. Any other association would be discretionary for HIPAA.

Q. ***If my insurance is through a MEWA or bonafide association, will it be subject to the Acts?***

A. Yes -- these group policies are subject to portability, limits on preexisting conditions, supplying and recognizing certificates of coverage, guaranteed issue (for all employers eligible to join the association or MEWA and all eligible individuals of those employers with no health status criteria), renewability for the employers and individuals as long as the MEWA or association offers insurance. If the insurance coverage offered by the association or MEWA is through an insurance carrier, then the insurance carrier is also subject to its guaranteed renewability provisions, not only to the MEWA or association, but if those entities discontinue insurance, then the carrier is obligated on a guaranteed renewability basis to each of the employers or individuals. Also, the insurance carrier can cancel and individual's policy when the individual loses membership in the association.

Q. ***What if the association is discretionary (that is, it is not a bona fide association)?***

A. For individuals it would be subject to the guaranteed renewability

requirement for all eligibles. If it was accepting small employers, it would be subject to guaranteed issue, portability, and guaranteed renewability, with all those implications. If the association was accepting any large employers, then it would also be subject to guaranteed renewability and portability.

Q. ***When would my MEWA or association be subject to the Acts?***

A. They would be subject to the Acts on the plan anniversary that occurred July 1, 1997, or the first anniversary thereafter before July 1, 1998. If the association has no plan anniversary, then it would be effective July 1, 1998.

Q. ***Can each MEWA or association have a unique plan even though it has guaranteed issue and has small employers in it?***

A. Yes.

Q. ***Must MEWA and association forms be filed in the State of Arkansas?***

A. Yes -- see ACA § 23-86-106.

◆ ***Individual Eligibility for Coverage***

Q. ***Would individuals who purchase individual insurance from an individual insurance carrier be subject to underwriting, preexisting conditions, exclusions, ratings, or even rejection?***

A. Yes -- but if they are rejected by an insurance carrier, they can seek coverage from the State risk pool (CHIPS). If they are Federally eligible, which means they have at least 18 months of coverage without a 63 day break under a group plan, they can receive credit for this against the preexisting condition only with CHIPS. If they have some creditable coverage, but less than 18 months, they can with CHIPS (for a fee not to exceed 10 percent of the premium) get credit for the number of months of creditable coverage up to the 6 month preexisting condition clause in the CHIPS policies.

Q. ***Are there any special requirements for insurance carriers issuing individual insurance?***

A. Yes -- we expect the insurance carriers to disclose to the purchaser of an individual policy, at least by the time the policy is issued, that if the purchaser has creditable coverage they could go to the CHIPS pool and not be subject to any preexisting condition clauses or any other exclusions or ratings that may be applied. We expect this disclosure to be made by the carriers if, in fact, they reject the potential policyholder.

Q. ***As an individual what impact will my health have on getting insured by a group health plan for which I would otherwise be eligible?***

A. Once the group plan has had an anniversary on or after July 1, 1997, it

cannot establish rules for individual eligibility based on health status related factors, or charge an individual different premiums based solely on those factors.

◆ ***The State Risk Pool (CHIPS)***

Q. ***Can my insurance ever be cancelled?***

A. Yes -- your insurance can be cancelled for fraud on your part or nonpayment of premiums. In addition, your insurance carrier can nonrenew your coverage, but this is a very limited situation. The carrier must nonrenew all business in a specific broad market in the State, and cannot write in that market for 5 years. In addition, it is possible that your employer may decide not to renew your insurance, since the employer is under no obligation to continue offering insurance. If your coverage is nonrenewed and you have available no other group coverage or COBRA, you can always apply to the CHIPS plan if you are Federally eligible (18 months of creditable coverage). The CHIPS plan in Arkansas is administered by Arkansas BlueCross BlueShield at P.O. Box 2181, Little Rock, AR 72203-2181. CHIPS can be reached throughout the State at 1-800-238-8379 or 1-501-378-3060.

Q. ***What if I'm not currently covered by any insurance and cannot get insurance?***

A. Under those conditions, you can apply to the CHIPS pool and if you cannot get insurance or even reasonably priced insurance, the CHIPS pool will take you subject to a 6 months preexisting condition clause.

Q. ***Can I voluntarily stop paying my premiums on my individual policy and instead join CHIPS?***

A. No -- you must be a Federally eligible individual, which means you have 18 months of creditable coverage and have no other coverage available to you. If, after you lapse your other policy, you apply to another insurance company and are rejected or have a substantial rate-up, then you would be eligible for CHIPS. CHIPS would not allow you to get credit against the 6 month preexisting clause for the time you were covered by the individual insurance that you voluntarily terminated.

◆ ***Nonrenewing by a Carrier***

Q. ***If a carrier withdraws from the market (for example association, individual, small group, or large group in Arkansas), must it nonrenew all of the existing business in that market?***

A. No -- it can still leave its existing business in force. It could, as part of that procedure, nonrenew all the business in that market, and it can do so as permitted in the contract, which usually would be on the next anniversary date. The company could not sell major medical in the market where it just nonrenewed its major medical business, but it could continue to sell limited benefits in that same market.

Q. ***If a carrier withdraws from a market but does not nonrenew its existing***

business, may it add new entrants (new employees, dependents)?

A. Yes.

◆ ***Certificates of Coverage (17-23)***

Q. ***When must certificates of coverage be provided?***

A. They must be provided on or after June 1, 1997, upon the termination of either group or individual coverage. In addition, they must be provided at the end of any COBRA coverage which applies to any group plan of 20 or more employees, and is usually for a term of 18 months. For group plans of less than 20 employees in the State of Arkansas a second certificate must also be provided at the end of the 120 days required by Arkansas, which could be considered a mini COBRA. In addition, another certificate of coverage must be provided upon request of the insured anytime within 24 months after termination of coverage. Arkansas requires that the certificate of coverage be provided at the latest within 30 days of the notice of termination or the request by the employer or insured.

Q. ***Must a carrier issue a certificate of coverage when an insured is just switching plans during an open enrollment period?***

A. No -- unless requested by the insured. Note that administratively a carrier may not know if someone has switched plans or terminated, and if terminated a certificate must be issued.

Q. ***Who must supply a certificate of coverage?***

A. All group and individual insurance health plans, including but not limited to, insurance carriers, HMOs, Medicaid, ERISA groups, self-funded groups, associations, MEWAs, church groups and government employee group health plans.

Q. ***Can the new carrier request a certificate of coverage from a prior carrier?***

A. The new carrier can request it, but the original carrier is not obligated to provide it. The obligation to provide a certificate of coverage is only to the insured under the circumstances described above. Once the new carrier receives the certificate of coverage from the insured, then the new carrier can request certain benefit information under the alternative method which would include benefits for dental, vision, drugs, or mental health. The prior carrier can charge the new carrier for this information if the new carrier asks for it. That is the only circumstance under which the old carrier must provide information to the new carrier, but we do encourage cooperation between the old and new carrier in order that continuation of coverage may be reasonably maintained.

Q. ***What tolls the 63 day break?***

A. The submission of an application, group or individual, that is relatively

complete would cause the 63 day break measure to be suspended. Counting for the 63 day break would restart on the date that such application was declined, provided the application was not wrongfully declined.

◆ ***Benefit Designs***

Q. ***Can a group health plan apply preexisting conditions to particular coverages?***

A. Yes -- it can apply preexisting condition clauses to dental, vision, mental health and drugs separate from other coverages, but credit must be given against the preexisting condition clause for each of these benefits if, in fact, they were covered under prior coverage.

Q. ***Can a group health plan exclude certain benefits for a period of time.***

A. Yes -- but the form must be filed and approved in the State of Arkansas. Arkansas will not allow the exclusion of such an array of benefits that in effect reestablishes a preexisting condition clause. Arkansas would consider, for example, if a transplant benefit is being offered in the new coverage, that some temporary limitation as regards time or benefit would be permitted. Also, some temporary time limit on maternity coverage, if such is offered, would be considered. No exceptions in the small group market would be considered based solely on health status.

Q. ***What type of insurance do the Acts apply to.***

A. Comprehensive major medical and comparable coverages, for example HMO coverage. 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.

Q. ***Is short term limited duration medical coverage considered comprehensive major medical for certificate of coverage purposes, or any other purposes, under the Acts?***

A. Yes.

Q. ***Is my supplemental cancer policy subject to the Acts?***

A. No -- unless it is coordinated with your major medical plan.

Q. ***Am I entitled to family coverage in my new plan if I had that before?***

A. You are entitled to family coverage only if that is what is offered under the new plan. The new employer may offer no coverage, or offer only individual employee coverage, or even individual coverage only to each separate member of the family.

- ***Maternity (39-40)***

Q. ***Did Arkansas pass a maternity bill similar to or more comprehensive than HIPAA?***

A. Arkansas passed the Arkansas Healthcare Consumers Act (Act 1196 of 1997) which, among other things, did the same thing as the HIPAA maternity and newborn bill in requiring that carriers allow the possibility of 48 hours in the hospital for a normal birth and 96 hours for a cesarean section. Note that the Federal law requires that maternity be offered to groups of 15 or more, and it must be covered as any other illness is covered.

- ***Mental Health***

Q. ***Did Arkansas pass a mental health parity bill?***

A. Arkansas passed the Mental Health Parity Act (Act 1020 of 1997). Arkansas' Act requires that in the large group market there be parity not only in calendar year and lifetime limits, but in all other financial and duration limits (for example, deductibles and number of days of coverage). In the individual and small group market only, an offer of mental health coverage must be made. If the company can show that its premiums would increase by 1-1/2 percent or more, it is not subject to this Act. The Act is effective August 1, 1997. For details see the Act and separate Regulation. Please note that meeting the mental health parity requirements of Arkansas would, in fact, meet the Federal requirements. An exception under the Federal requirements would create an exception under the Arkansas requirements. An exception granted under the Arkansas requirements may still not indicate that a company meets the requirements for an exception under the Federal law.

- ***Medical Savings Accounts***

Q. ***Can I purchase a medical savings account in Arkansas?***

A. Yes -- Arkansas permits the product and also permits tax deductibility based on the same rules as are used for Federal tax deductibility. These rules include that you must be self-employed or a small employer without prior insurance. An insurance carrier that sells medical savings accounts and your tax consultant should be consulted for details.

- ***Guaranteed Renewability and Medicare Supplement***

Q. ***If an employer keeps an employee past age 65, must they provide coverage?***

A. Yes -- the employee who is eligible (e.g. an employee and full time) is guaranteed renewable. Benefits can be coordinated with medicare if the policy provides for coordination of benefits.

Q. ***Can I renew my comprehensive major medical policy past age 65?***

A. Yes -- but the insurance carrier can impose a coordination of benefits

provision if it notifies the Arkansas Insurance Department and you. In addition, the insurance carrier can enforce your being allowed the option of choosing either a medicare supplement policy or the major medical policy. This is your choice, but the insurance carrier can insist that you may have only one of those products.

Q. ***What must the insurance carrier do to offer a coordination of benefits clause beyond age 65 if it did not exist in its current policy when the policy was not renewable beyond age 65?***

A. The insurance carrier must file an amendment with the State of Arkansas and mail it to all insureds in order to include a coordination of benefit clause for ages beyond age 64 in the event the policy is renewed by the insured beyond that age, and the policy did not have a prior coordination of benefits clause.

Q. ***What notifications must the insurance carriers provide to the insureds?***

A. Before the insured turns 65, the insurance carrier must notify them that the policy is renewable beyond age 65 if, in fact, their policy said that it was not renewable beyond that age. The company must notify the policyholder if it intends to apply a coordination of benefits provision beyond age 65 if that was not in the policy before. The company must disclose to you information about medicare supplement options, including the fact that the issue of such a policy is guaranteed for only a limited period of time. It must also indicate to you how benefits will be paid after you are covered by medicare, whether you have a medicare supplement policy or whether you maintain the major medical policy. It must also indicate to you that your delay in enrolling for a medicare supplement policy could result in you not being eligible at all in the future for such a policy, and if you are, that premiums could be substantially higher. In addition, they must indicate to you the possibility that the premiums on your major medical policy could, in fact, increase beyond age 65 if, in fact, that is the case.

Q. ***Which policies are to be considered to be major medical policies for the purpose of the Acts?***

A. There are fairly standard and general definitions as to what major medical is in the market place. We do understand that there are older policies that may not neatly fit into one definition or another. We would expect with any rate filings on older policies, that the actuarial certification address the category that the policy falls in with an appropriate explanation. Such policies that have not been reviewed because of the lack of a rate filing should be considered to be available for review with an appropriate explanation at the time of a financial examination or a market conduct examination.

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