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RULE AND REGULATION 32

MINIMUM STANDARDS FOR INDIVIDUAL POLICIES OR CERTIFICATES ISSUED UPON CONVERSION FROM A GROUP DISABILITY INSURANCE POLICY

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SECTION 1. PURPOSE

The purpose of this rule is to implement Ark. Stat. Ann. §§66-3731 through 66-3735, so as to provide minimum standards for policies, certificates or contracts, hereinafter referred to as "The Converted Policy", issued pursuant to a conversion privilege under a policy or contract of group insurance, including but not limited to group policies issued by Insurance Companies, Hospital and Medical Service Corporations, Health Maintenance Organizations, Certificates of

fraternal Benefit Societies, and self-insurers not excluded from the jurisdiction of this Department by Ark. Stat. Ann. §§66-2019 through 66-2026.

SECTION 2. AUTHORITY

This rule is issued pursuant to the authority vested in the Commissioner under Ark. Stat. Ann. §§66-2026, 66-2111, and 66-3732.

SECTION 3. SCOPE

This rule shall apply to all of the converted policies and certificates delivered or issued for delivery on or after the effective date hereof, and should be read in addition to and supplementary to Ark. Stat. Ann. §§66-3731 through 66-3735.

SECTION 4. EFFECTIVE DATE

The provisions of this rule shall become effective January 1, 1988, as to all policies and certificates filed with the Department for approval. Any policy or certificate delivered or issued for delivery in this State on or after January 1, 1988 must be in compliance with the provisions of this rule.

SECTION 5. DEFINITIONS

No converted policy delivered or issued to be delivered in this State shall contain definitions which do not comply with Rule 18, Section 5 of the Arkansas Insurance Department Regulations, which is hereby incorporated by reference.

SECTION 6. TIME LIMIT

Written application for the converted policy shall be made and the first premium paid to the insurer not later than thirty (30) days after such termination.

SECTION 7. EVIDENCE OF INSURABILITY

The converted policy shall be issued without evidence of insurability.

SECTION 8. EFFECTIVE DATE OF COVERAGE

The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

SECTION 9. SCOPE OF COVERAGE

The converted policy shall cover the employee or member and his dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

SECTION 10. OPTIONAL COVERAGE

The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by Medicare (Title XVIII of the United States Social Security Act as added by the Social Security amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if

(a)(i) such person is covered for similar benefits by another hospital, surgical, medial or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; or

(ii) such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on uninsured or uninsured basis, or

(iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law, and

(b) the benefits provided under the sources referred to in (i) above for such person, or benefits provided or available under the sources referred to in (ii) and (iii) above for such person, together with the benefits provided by the converted policy, would result in over-insurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the Commissioner of Insurance prior to their use in denying coverage.

SECTION 11. INFORMATION REQUESTED BY INSURER

A converted policy may include a provision whereby the insurer may request information in advance of any premium due date of such policy of any person covered thereunder as to whether (i) he is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, (ii) he is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or (iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law. The converted policy may provide that the insurer may refuse to renew the policy or the coverage of any person insured thereunder the following reasons only:

(a) either the benefits provided under the sources referred to in (i) and (ii) above for such person, or benefits provided or available under the sources referred to in (iii) above for such person, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards on file with the Commissioner of Insurance, or the converted policyholder fails to provide the request information;

(b) fraud or material misrepresentation in applying for any benefits under the converted policy;

(c) eligibility of the insured person for coverage under Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy;

(d) other reasons approved by the Commissioner of Insurance.

SECTION 12. BENEFITS OFFERED

An insurer shall not be required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made. The converted policy may contain any exclusion, reduction, or limitation contained in the group policy and any exclusion, reduction, or limitation customarily used in individual health policies delivered or issued for delivery in this State, unless those provisions conflict with any parts of this regulation.

SECTION 13. PREEXISTING CONDITION

The converted policy shall not exclude a preexisting condition not excluded by the group policy. However, the converted policy may provide that any hospital, surgical or medical benefits payable thereunder may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual's insurance thereunder. The converted policy may also include provisions so that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and in effect.

SECTION 14. OPTIONAL COVERAGE - HOSPITALIZATION OR SURGICAL EXPENSE

Subject to the provisions and conditions of this rule, if the group insurance policy from which conversion is made insures the employee or member for basic hospital or surgical expense insurance, the employee or member shall be entitled to obtain a converted policy providing coverage on an expense-incurred basis under plans meeting the following requirements:

Plan A

(a) hospital room and board daily expense benefits in a maximum dollar amount approximately the average semi-private rate charged in metropolitan areas of this state, for a maximum duration of seventy days,

(b) miscellaneous hospital expense benefits of a maximum amount of ten times the hospital room and board daily expense benefits, and

(c) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of eight hundred dollars, or

Plan B

(a) hospital room and board daily expense benefits in a maximum dollar amount equal to 75% of the maximum dollar amount determined for Plan A, for a maximum duration of seventy days,

(b) miscellaneous hospital expense benefits of a maximum amount of ten times the hospital room and board daily expense benefits, and

(c) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of six hundred dollars, or

Plan C

(a) hospital room and board daily expense benefits in a maximum dollar amount equal to 50% of the maximum dollar amount determined for Plan A, for a maximum duration of seventy days,

(b) miscellaneous hospital benefits of a maximum amount of ten times the hospital room and board daily expense benefits, and

(c) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of four hundred dollars.

The maximum dollar amount in Plan A is determined to be $150.00. A redetermination may be made once in three years (3). The maximum dollar amounts in Plan A, B and C shall be rounded to the nearest multiple of $10.00.

SECTION 15. OPTIONAL COVERAGE - MAJOR MEDICAL

Subject to the provisions and conditions of this rule, if the group insurance policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(a) A maximum benefit at least equal to either, at the option of the insurer, (i) or (ii) below:

(i) The smaller of the following amounts:

(1) The maximum benefit provided under the group policy.

(2) A maximum payment of $250,000 per covered person for all covered medical expenses incurred during the covered person's lifetime.

ii) The smaller of the following amounts:

(1) The maximum benefit provided under the group policy.

(2) A maximum payment of $250,000 for each unrelated injury or sickness.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at the rate of 100% during the reminder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than 50%.

(c) A deductible for each benefit period which, at the option of the insurer, shall be (i) the sum of the benefits deductible and $100, or (ii) the corresponding deductible in the group policy. The term "benefits deductible", as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect t covered medical expenses by any other hospital, surgical, or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in accordance with the requirements of any state or federal law and, if pursuant to Section 17 hereof, the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by (a)(ii) above, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is $100 or less, and not less than six months if the deductible exceeds $100.

(d) The benefit period shall be each calendar year when the maximum benefit is determined by (a)(i) above or twenty-four months when the maximum benefit is determined by (a)(ii) above.

(e) The term "covered medical expenses", as used above, shall include at least, in the case of hospital room and board charges, the lesser of the dollar amount in Plan A and the average semi-private room and board rate for the hospital in which the individual is confined and twice such amount for charges in an intensive care unit. Any surgical schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a $1,600 maximum benefit.

SECTION 16. BENEFIT PLANS UNDER SECTIONS 15 AND 16

A. The conversion policy shall, if the group insurance policy insurers that employee or member for basic hospital or surgical expenses insurance, make available the plans of benefits as set forth in Sections 15 and 16 hereof. At the option of the insurer, such plans of benefits may be provided under one policy.

B. The insurer may also, in lieu of the plans of benefits set forth in Sections 15 and 16 above, provide a policy of Comprehensive Medical Expense Benefits without first dollar coverage. Such policy shall conform to the requirements of Section 16, provided, however, that an insurer electing to provide such a policy shall make available a low deductible option, not to exceed $100, a high deductible option between $500 and $1,000, and a third deductible option midway between the high and low deductible options.

SECTION 17. ALTERNATE PLANS

The insurer may, at its option, also offer alternative plans, with benefits in excess of those required by this rule.

SECTION 18. COVERAGE OF RETIREMENT

In the event coverage would be continued under the group policy on an employee following his retirement prior to the time he is or could be covered by Medicare, he may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had his insurance terminated at retirement by reason of termination of employment or membership.

SECTION 19. COORDINATION OF BENEFITS DUE TO MEDICARE

the converted policy may provide for coordination of benefits provided under Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded) or under any other governmental programs with the exception of Medicaid.

SECITON 20. CONVERSION PROVILEGE ALLOWED

Subject to the conditions set forth above, the conversion privilege shall also be available (i) to the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents coverage following the employee's or member's death, at the end of such continuation, (ii) to the spouse of the employee or member remains insured under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time, or (iii) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

SECTION 21. BENEFIT LEVELS

If the benefit levels required in Section 14 above exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in Section 14.

SECTION 22. GROUP IN LIEU OF INDIVIDUAL COVERAGE

Nothing contained herein shall be construed to prevent the insurer from providing group coverage rather than the issuance of a converted individual policy. Any certificate of insurance issued pursuant to this regulation must comply with every provision of this regulation including Section 23 "Conversion Premium". Every premium rate charged for a certificate of insurance must be approved prior to its use in this State.

SECTION 23. CONVERSION PREMIUM

The initial premium for the converted policy for the first twelve (12) months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks, to the age and class of risk of each person to be covered under the converted policy and to the type and amount of insurance provided. The experience under converted policies shall not be an acceptable basis for establishing rates for converted policies.

However, if an insurer experiences incurred losses, for a period of two (2) years, on conversion policies which have been in force for at least one (1) year, which exceed earned premiums, the insurer may file, with the Commissioner of Insurance, amended renewal rates for the subsequent year, which will produce a loss ratio of not less than one hundred percent 100%).

SECTION 24. SEVERABILITY

Any section or provision of this rule held by a court to be invalid or unconstitutional will not affect the validity of any other section or provision.

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Robert M. Eubanks III
Insurance Commissioner

_____November 19, 1987_____
Date