ARKANSAS INSURANCE DEPARTMENT
LEGAL DIVISION
1200 West Third Street
Little Rock, AR 72201-1904
501-371-2820
FAX 501-371-2629

RULE AND REGULATION NO. 52
MINIMUM STANDARDS FOR MINIMUM BASIC BENEFIT DISABILITY INSURANCE

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Section 1. Purpose.

The purpose of this Rule and Regulation is to implement the requirements of Act 238 of 1991, in order to provide minimum standards for basic benefit disability insurance and regulate the development of basic benefit disability insurance for qualified groups, families and individuals and regulate the marketing and administrative costs of such insurance.

Section 2. Authority.

This Rule and Regulation is issued pursuant to the authority vested in the Commissioner by Sections 4 through 12 of Act 238 of 1991, Arkansas Code Annotated §§23-61-108 and 25-15-201.

Section 3. Definitions.

A. "Commissioner" shall mean the Arkansas Insurance Commissioner;

B. "Insured" shall mean any individual or group insured under a minimum basic benefit policy issued pursuant to the provisions of Act 238 of 1991 and this Rule and Regulation;

C. "Insurer" means an insurer, health maintenance organization, hospital or medical services corporation offering a minimum basic benefit policy pursuant to Act 238 of 1991;

D. "Loss Ratio" means the percentage derived by dividing incurred claims (both reported and not reported) by the total premiums earned;

E. "Permitted Coverages" shall mean health or hospitalization coverage under a minimum basic benefit policy issued pursuant to Act 238 of 1991, under medicaid, medicare, limited benefit policies as defined by Rule and Regulation 18, COBRA or the provisions of Ark. Code Ann. §§23-86-114, 23-86-115 or 23-86-116;

F. "Minimum Basic Benefit Policy" shall mean a policy offered by an insurer to a qualified individual, qualified family, or qualified group pursuant to the provisions of Act 238 of 1991 and this rule;

G. "Qualified Family" means individuals all of whom are qualified individuals and all of whom are related by blood, marriage, or adoption;

H. "Qualified Group" means a group of twenty-five people or less, organized other than pursuant to Section 4 of Act 238 of 1991, in which each covered individual, or covered dependent of such covered individual, within the group is a qualified individual: provided a "qualified group" may include less than all employees of an employer;

I. "Qualified Individual" means an individual who is employed in or is a resident of Arkansas and who has been without health insurance coverage, other than Permitted Coverage, for the twelve (12) month period immediately preceding the effective date of a minimum basic benefit policy issued pursuant to Act 238 of 1991 and who meets reasonable underwriting standards; provided, children newborn to or adopted by an insured after the effective date of a policy issued to the insured pursuant to Act 238 which covers the insured and members of the insured's family, shall be considered qualified individuals.

J. "Qualified Trust" means a group organized pursuant to Section 4 of Act 238 of 1991 in which each covered individual, or covered dependent of such covered individual, within the group is a qualified individual;

K. "Children's Preventive Health Care Services" means physic ian-de livered or physician-supervised services for eligible dependents from birth through age six (6), with periodic physical examinations including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards;

L. "Periodic Physical Examinations" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice; and

M. "Primary and Preventive Care" means that medical care provided to a covered individual which constitutes the first level of entry into the health care system and includes routine diagnostic office visits, routine health screening not related to reproductive or sex organ systems, preventative immunizations and routine periodic physical examinations.

N. "Medically Necessary" means the treatment, services, medicines, or supplies necessary and appropriate for the diagnosis or treatment of a sickness or injury which is provided in accordance with generally accepted professional standards.

Section 4. Required policy provisions.

All minimum basic benefit policies issued pursuant to Act 238 of 1991 and this Rule and filed with the Commissioner for approval shall at the minimum contain coverage at the following levels for the benefits prescribed:

A. Inpatient hospitalization coverage of fifteen (15) days per year. Inpatient hospitalization shall be defined in the policy no more strictly than those services rendered to an insured who is confined in a Hospital as a registered bed patient and which includes room and board in a semi-private room, special care ward or, when medically necessary, a private room and all medically necessary examinations, laboratory procedures or tests, any other tests, procedures, or treatment deemed appropriate by the treating physician, as well as coverage for medicine, supplies and equipment charges incurred during the inpatient hospitalization;

B. Two (2) office or clinic visits per year for Primary and Preventative Care, including outpatient surgery or other treatment or therapy rendered on an outpatient basis. The insured may be required to pay a co-payment as specified in Section 4(D) for such treatment.

C. An annual deductible for inpatient hospitalization and outpatient surgery of Five Hundred Dollars ($500.00) per year per covered person. The maximum annual deductible for family coverage is One Thousand Dollars ($1,000.00).

D. Insured co-payment provision of no more than thirty percent (30Z) of the actual covered charge up to Five Thousand Dollars ($5,000). No co-payment shall be required of an insured for covered charges exceeding Five Thousand Dollars ($5,000) up to the annual maximum benefit provided in the policy;

E. The annual maximum benefit provided shall be no less than $100,000 per policy or certificate of enrollment. The lifetime maximum benefit provided shall be no less than $250,000 per policy or certificate of enrollment;

F. Provisions for a maximum differential of no more than twenty-five (25Z) percent for services rendered by a non-preferred provider for plans incorporating preferred provider arrangements as a part of a managed cost program. This subsection shall apply to all benefits offered pursuant to this Rule and Regulation;

G. A waiting period for coverage of pre-existing conditions of no more than six (6) months from the effective date of coverage;

H. All group policies issued pursuant to this Rule and Regulation shall contain those provisions required by Arkansas Code Annotated §§23-86-108(7)(A), 23-86-114, 23-86-115, and 23-86-116, except that no minimum basic benefit policy shall be required to comply with §23-86-108(7)(A) unless replacing another minimum basic benefit policy approved by the Commissioner pursuant to this Rule and Regulation and Act 238 of 1991; and

I. Every policy issued pursuant to this chapter which covers the insured and members of the insured's family shall include coverage for newborn infant children of the insured from the moment of birth, and for adopted minors from the date of the interlocutory decree of adoption; provided, the insurer may require that the insured give notice to his insurer of any newborn children within ninety (90) days following the birth of such newborn infant and of any adopted child within sixty (60) days of the date the insured has filed a petition to adopt. The coverage of newborn children or adopted children shall not be less than the same as is provided for other members of the insured's family.

Section 5. Prohibited policy provisions.

A. No policy issued pursuant to this Rule and Regulation and Act 238 of 1991 as a minimum basic benefit policy shall provide for coverage or benefits required to be offered pursuant to the following provisions of the Arkansas Code: Ark. Code Ann. §23-79-129, §23-79-130, §23-79-137, §23-79-139, §23-79-140, §23-79-141, §23-85-131(b), §23-85-137, §23-86-108(4), §23-86-118, and §23-86-113.

B. Insurers may file with this Department for approval as minimum basic benefit policies, policy forms which contain higher or lower benefit levels than specified by Section 4 and Section 6 of this Rule and Regulation. Provided, however, no insurer may file any policy for approval as a minimum basic benefit policy which contains any provision excluded by Section 5(A) of this regulation. Provided further, that insurers may only file policies for approval pursuant to this subsection after filing and receiving approval and offering for sale a minimum basic benefit policy form containing those benefit levels as provided in Section 4 and Section 6 of this Rule and Regulation.

Section 6. Required options.

Every policy offered for sale as a basic benefit policy shall give the insured the option of purchasing the following coverages, subject to underwriting guidelines:

A Children's Preventive Health Care coverage for services rendered at the following age intervals by a single physician during the course of one visit:

> Birth, two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, eighteen (18) months, two (2) years, three (3) years, four (4) years, five (5) years, and six (6) years.

B. Benefit for Children's Preventive Health Care shall be reimbursed at levels equal with the levels established for the same services under the medicaid program in the State of Arkansas. Furthermore, all co-payments and other amounts payable by insureds pursuant to Section 4 of this Rule and Regulation shall be applicable to benefits payable for Children's Preventive Health Care.

C. Prenatal Care coverage shall be offered which includes coverage for one prenatal visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth month of pregnancy, and one office visit per week during the ninth month until term. Coverage shall include all necessary examinations, laboratory and diagnostic procedures and tests deemed appropriate by the treating physician.

D. Obstetrical care shall be offered which includes physician services, delivery room and other medically necessary hospital services.

Section 7. Waiting Periods; Limitations.

Except as provided in Section 4(F), there shall be no probationary or waiting period during which no coverage is provided under the policy. However, Section 4(G) shall not apply to basic benefit policy which replaces coverage of another basic benefit policy.

Section 8. Rates; Filing Requirements.

Rates pertaining to basic benefit policies shall be filed with the Commissioner no less than sixty (60) days prior to intended use, and shall be approved by the Commissioner prior to implementation. All rates submitted shall meet the following requirements:

A. All rates shall be based upon a pool, community rating, or other rating formula acceptable to the Commissioner;

B. No rate shall be approved unless accompanied by a statement from a qualified actuary certifying the reasonableness of the proposed rate. Such statement shall outline the actuary's qualifications, and the Commissioner may disapprove any rate filing accompanied by a statement from an actuary he deems to be unqualified. Such actuary shall possess the qualifications outlined in Arkansas Insurance Department Rule and Regulation 16, section 4 or such other qualifications as the Commissioner shall approve;

C. All rates submitted for group policies shall be based upon a loss ratio of not less than seventy-five (75%) percent;

D. All rates submitted for individual policies shall be based upon a loss ratio of not less than sixty-five (65%) percent;

E. All rates submitted pursuant to this Rule shall be accompanied by a statement from the insurer of the portion of the rate or premium applicable to the coverages provided for the basic benefit policy. All such statements shall be made on forms provided by the Commissioner.

F. Any insurer wishing to appeal a denial of a rate request should make a written request for hearing pursuant to A.C.A §25-15-101, et §tq.

Section 9. Underwriting Guidelines.

A. No claim shall be reduced or denied on the ground that the disease or physical condition for which claim is made pre-existed the effective date of the policy coverage and was not disclosed by the insured, unless the insurer has evidence that such disease or physical condition had manifested itself prior to the effective date of coverage for the disease or physical condition, and unless information on such disease or physical condition was requested on the application for insurance coverage. No claim shall be reduced or denied on such grounds unless the manifestation of the disease is established by proof of medical diagnosis or treatment of such disease or physical condition prior to the effective date of coverage for the disease or physical condition.

B. An insurer may rescind a minimum basic benefit policy within the first three years after the policy inception only upon receipt of information concerning the insured's state of health, and a finding thereon that the insured failed to disclose or misrepresented material information contained on the application. Material information is that information concerning the insured's physical condition or past treatment which would, if disclosed, resulted in refusal to accept that insured or others treated for the same condition or in substantially the same condition as the insured. The burden of proof in cases in controversy before the Department shall be on the insurer.

C. An insurer may rescind a minimum basic benefit policy after three years only upon a showing of willful fraud by an insured as to that insured's physical condition or the physical condition of an insured's covered dependant.

D. Qualified members of groups or trusts holding minimum basic benefit policies shall not be subject to individual underwriting procedures or standards normally applied to individuals holding a minimum basic benefit policy.

Section 10. Cancellations, Renewals.

All basic benefit policies issued to a qualified group or trust shall contain a "noncancellable", "guaranteed renewable", or "non-cancellable and guaranteed renewable" provision which provides that the policy shall not be subject to termination of coverage of the insured or the insured's dependents, other than for nonpayment of premium or material willful fraud on the part of the insured which substantially increases the risk to the insurer.

Section 11. Disclosure and Notice.

Insurers offering for approval a basic benefit policy shall provide, separate from the policy, a disclosure to the insured which contains the following information:

1. An outline of the extent of coverage;

2. A specific list of the mandated benefits not provided;

3. An explanation of any managed care and cost control features, including all necessary telephone numbers and addresses; and

4. An explanation of the primary and preventative care features of the policy.

All disclosure statements shall use terminology and language which is easily understood by the average consumer. The type used on the statements shall be pica size and the disclosure statement shall contain the following statement in twelve point bold faced type:

> THIS IS A BASIC BENEFIT POLICY AND CONTAINS COVERAGE WHICH IS STRICTLY LIMITED IN NATURE AND DOES NOT CONTAIN BENEFITS WHICH WOULD BE PROVIDED UNDER A COMPREHENSIVE MAJOR-MEDICAL POLICY. READ YOUR POLICY CAREFULLY.

A place for the insured's signature shall be provided under the statement, and no policy shall be issued unless the disclosure statement is properly signed by the insured, and the original of such retained in the records of the insurer for the duration of coverage. The insured shall be provided a copy of the statement so retained by the insurer. All disclosure statements shall be filed along with the policy form for approval by the Commissioner.

Section 12. Notice to Employees.

Employers not providing a portion of the cost of health insurance for their employees shall post the notice provided in Appendix A of this Rule and Regulation for the benefit of their employees at the place of employment or in any other reasonable manner.

Section 13. Qualified Trusts; Formation and Regulation.

Two or more qualified individuals, qualified families or qualified groups may make application for a certificate of approval to the Commissioner in order to form a qualified trust pursuant to Act 238 of 1991 and this Rule and Regulation. Such trust may exist solely for the purpose of obtaining minimum basic benefit policies.

A. All applicants for a certificate of approval under this section shall make application on the forms provided by the Commissioner and shall submit the following:

1. A copy of the trust agreement to be signed by all members of the trust;

2. A copy of any agreements with third parties to administer the trust;

3. A plan of management including the method of collection and billing for premiums, administrator fees and other expenses of the trust;

4. A copy of the proposed master basic benefit policy; and

5. A copy of the form of enrollment or certificate to be issued to the trust members evidencing coverage.

B. All administrators of trusts organized under this Rule and Regulation shall comply with the provisions of Arkansas Code Annotated §23-92-201 through §23-92-208 in the manner as those third party administrators covered under such Code provisions.

C. Upon receipt of approval from the Commissioner, the trust shall be allowed to conduct its business. Any trust wishing to make a modification of the information required in Section 4(A) shall file a request for approval with the Commissioner prior to instituting the requested change.

Section 14. Record Keeping; Annual Statements.

Each insurer issuing a minimum basic insurance policy in this state shall maintain a separate annual record of information as to its business in minimum basic insurance policies the form for which shall be provided by the Commissioner. Such record shall contain the following information:

1. Total number of minimum basic benefit policy insureds listed by type of insured as follows:

    (a) Number of qualified individuals;
    (b) Number of qualified groups;
    (c) Number of qualified trusts;

2. Number of policy options sold, listed by type of option offered;

3. Amount of premium written;

4. Total amount of claims incurred; and

5. Total amount of claims paid.

Such record shall be attested by the president of the insurer and submitted to this Department annually by March 1 for the preceding year ending December 31 as an exhibit to the insurer's annual statement.

Section 15. Advertising.

A. Every insurer marketing a minimum basic benefit policy in this state, shall provide a copy of any advertisement intended for use whether through written, radio or television medium to the Commissioner for review and approval by the Commissioner.

B. Every insurer marketing a basic benefit policy in this state shall comply with the following standards of marketing:

1. Establishment of marketing procedures to assure fair and accurate comparison of policies by agents or other producers.

2. Display by type, stamp or other appropriate means on the first page of any written marketing material or outline of coverage the following:

"NOTICE TO BUYER: This is a basic benefit policy and does not contain benefits required by law to be provided by a major-medical disability policy."

3. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for basic benefit insurance is a qualified individual, qualified family, or qualified group having only had the permitted coverages for the twelve months preceding the application.

4. Every insurer or entity marketing basic benefit policies shall establish auditable procedures for verifying compliance with this Section.

C. No policy of insurance may use the words "basic benefit", "minimum benefit", "minimum basic benefit", "bare bones" or other such words or similar language in any policy, advertisement, brochure, or other materials which would lead the average consumer to assume that such policy has been approved by the Commissioner as a minimum basic benefit policy pursuant to Act 238 of 1991 unless the policy in question has been approved as a minimum basic benefit policy pursuant to this Rule and Regulation and Act 238 of 1991.

Section 16. Conversion to Medicare Supplement.

Every insurer shall offer a qualified insured who reaches the age of sixty-five (65), and who is covered as a named insured or a covered dependent under that insurer's basic benefit policy, conversion to a medicare supplement policy which complies with Arkansas Insurance Department Rule and Regulation 27, if such insurer issues medicare supplement policies.

Section 17. Effective Date.

This Rule and Regulation shall be effective upon signature of the Commissioner of Insurance.

(signed by Commissioner Douglass)
Lee Douglass
Insurance Commissioner
State of Arkansas

(dated May 13, 1992)
Date

APPENDIX "A"

NOTICE TO EMPLOYEES

YOU OR YOUR DEPENDENTS MAY BE ELIGIBLE FOR MINIMUM BASIC BENEFIT INSURANCE. YOU MAY CONTACT THE ARKANSAS INSURANCE DEPARTMENT AT 686-2875 OR THE ARKANSAS EMPLOYMENT SECURITY DIVISION AT 682-2257 FOR A LIST OF THOS2 INSURERS AUTHORIZED TO SELL SUCH POLICIES.