

Chapter 76.

Health Maintenance Organizations.

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23-76-101. Purpose.

- (a) The General Assembly determines that health maintenance organizations, when properly regulated, encourage methods of treatment and controls over the quality of care which effectively contain costs and provide for continuous health care by undertaking responsibility for the provision, availability, and accessibility of services.
- (b) For this reason, and because the primary responsibility of a health maintenance

organization lies in providing quality health care services on a prepaid basis without regard to the type and number of services actually rendered, rather than providing indemnification against the cost of the services, the General Assembly finds it necessary to provide a statutory framework for the establishment and continuing regulation of health maintenance organizations which is separate from the insurance laws of this state, except as otherwise provided in this chapter.

23-76-102. Definitions.

As used in this chapter, unless the context otherwise requires:

- (1) "Commissioner" means the Insurance Commissioner;
- (2) "Domestic corporation" means any corporation organized pursuant to the Arkansas Business Corporation Act, § 4-26-101 et seq., and the Arkansas Nonprofit Corporation Act, § 4-28-201 et seq.;
- (3) "Enrollee" means an individual who has been enrolled in a health care plan;
- (4) "Evidence of coverage" means any certificate, agreement, contract, identification card, or document issued to an enrollee setting out the coverage to which he is entitled;
- (5) "Health care plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services, and at least part of the arrangement consists of arranging for, or the provision of, health care services as distinguished from mere indemnification against the cost of the services on a prepaid basis through insurance or otherwise;
- (6) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization, or services incident to the furnishing of care or hospitalization, as well as the furnishing to any person of any and all other services or goods for the purpose of preventing, alleviating, curing, or healing human illness or injury;
- (7) "Health maintenance organization" means any person which undertakes to provide or arrange for one (1) or more health care plans;
- (8) "Health professional" means physicians, dentists, optometrists, nurses, podiatrists, pharmacists, and other individuals engaged in the delivery of health services as are or may be designated under the Health Maintenance Organization Act of 1973 or any amendment thereto or regulation adopted thereunder;
- (9) "Person" means any natural or artificial person including, but not limited to, individuals, partnerships, associations, trusts, or corporations; and
- (10) "Provider" means any person who is licensed in this state to furnish health care services as a health professional.

23-76-103. Applicability of the Insurance Code and laws concening hospital and medical service corporations.

- (a) Except as otherwise provided in this chapter, provisions of the insurance law and provisions of hospital and medical service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision shall not apply to an insurer or hospital and medical service corporation licensed and regulated pursuant to the insurance laws or the hospital and

medical service corporation laws of this state, except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

- (b) The provisions of § 23-76-101 et seq., the Arkansas Insurance Code, § 23-60-101 et seq., and the law concerning hospital and medical service corporations, § 23-75-101 et seq., or any amendments thereto, shall not be applicable to any nonprofit vision service plan corporation composed of at least fifty (50) participating licensed optometrists or ophthalmologists licensed by the State of Arkansas to provide vision care services on a prepaid basis, when each licensed optometrist or ophthalmologist is subject to the rules and regulations of the professional's respective state board, and when each participating licensed optometrist or ophthalmologist agrees to assume responsibility for completion of the provisions of the vision care services contracted for, so that no element of risk is incurred by any subscriber group or person.

23-76-104. Insurance Code sections applicable to health maintenance organizations.

Except to the extent that the Insurance Commissioner determines that the nature of health maintenance organizations, health care plans, and evidences of coverage render such sections clearly inappropriate, the following sections are applicable to health maintenance organizations:

- (1) Sections 23-60-101 - 23-60-108 and 23-60-110, referring to scope of the Arkansas Insurance Code;
- (2) Sections 23-61-101 et seq., 23-61-201 et seq., and 23-61-301 et seq., referring to the Insurance Commissioner;
- (3) Sections 23-63-102 - 23-63-104, 23-63-201 - 23-63-216, general provisions, and § 23-63-301 et seq., referring to service of process, a registered agent as process agent, serving legal process, and time to plead;
- (4) Section 23-63-601 et seq., referring to assets and liabilities, and §§ 23-63-901 - 23-63-912, referring to administration of deposits;
- (5) Sections 23-63-1501 et seq., referring to risk based capital requirements;
- (6) Sections 23-64-101 et seq. and 23-64-201 et seq., referring to agents, brokers, solicitors, and adjusters;
- (7) Sections 23-66-201 et seq., 23-66-301 - 23-66-306, and 23-66-308 - 23-66-314, referring to trade practices and frauds;
- (8) Sections 23-68-101 et seq., referring to rehabilitation and liquidation;
- (9) Section 23-69-134, referring to home office and records and the penalty for unlawful removal of records;
- (10) Section 23-69-156, referring to extinguishing unused corporate charters;
- (11) Sections 23-75-104 - 23-75-105, and 23-75-116, referring to hospital and medical service corporations;
- (12) Sections 23-79-101 - 23-79-107, 23-79-109 - 23-79-128, 23-79-131 - 23-79-134, and 23-79-202 - 23-79-210, referring to insurance contracts;
- (13) Sections 23-85-101 - 23-85-132, 23-85-134, and 23-85-136, referring to individual accident and health insurance;
- (14) Sections 23-86-101 - 23-86-104, 23-86-106, 23-86-108 - 23-86-111, 23-86-113

- 23-86-117, 23-86-119 - 23-86-120, 23-86-201 et seq., 23-86-301 et seq., and 23-86-401 et seq., referring to blanket and group accident and health insurance; and (15) Sections 23-99-101 et seq., referring to health care providers.

23-76-105. Penalties - Enforcement.

- (a) The Insurance Commissioner may, in lieu of suspension or revocation of a certificate of authority under § 23-76-123, levy an administration penalty in an amount not less than two hundred fifty dollars (\$250), nor more than two thousand five hundred dollars (\$2,500), if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.
- (b) Any person who willfully violates this chapter shall be guilty of a misdemeanor and may be punished by a fine not to exceed one thousand dollars (\$1,000) or by imprisonment for a period not exceeding one (1) year, or both fine and imprisonment.
- (c)(1) If the commissioner or the Director of the Department of Health shall for any reason have cause to believe that any violation of this chapter has occurred or is threatened, the commissioner or the director may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violations.
 - (2) Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the commissioner or the director may deem appropriate under the circumstances.
- (d)(1) The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this chapter.
 - (2) Within thirty (30) days after service of the order of cease and desist, the respondent may request a hearing on the questions of whether acts or practices in violation of this chapter have occurred. The hearings shall be conducted pursuant to the provisions of §§ 23-61-303 - 23-61-307, and judicial review shall be available as provided in § 23-66-212.
- (e) In the case of any violation of the provisions of this chapter, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d) of this section, the commissioner may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Circuit Court of Pulaski County for actions of this nature.

23-76-106. License to practice, sell, or dispense required.

No person shall perform any of the services or procedures or sell or dispense any goods or devices in the field of the healing arts for which a license is required under the laws of

the State of Arkansas unless such person holds a valid license authorizing him or her to perform the procedures, render the services, or sell or dispense the goods or devices.

23-76-107. Establishment.

- (a)(1) Any person that meets the requirements of § 23-76-102(9) may apply to the Insurance Commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization.
- (2) No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, nor solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate of authority under § 23-76-101 et seq.
- (3) The corporation must have the express authority to operate a health maintenance organization contained in its articles of incorporation. Incorporation shall not be required of any entity which has been issued a certificate of authority prior to March 30, 1987.
- (b)(1) Every health maintenance organization, as of July 9, 1975, shall submit an application for a certificate of authority under subsection (c) of this section within sixty (60) days of the effective date of this chapter.
- (2) Each applicant may continue to operate until the commissioner acts upon the application.
- (3) In the event that an application is denied under § 23-76-108, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.
- (c) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:
 - (1) A copy of the basic organizational document, if any, of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;
 - (2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;
 - (3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;
 - (4) A copy of any contract made or to be made between any providers or persons listed in subdivision (c)(3) of this section and the applicant;
 - (5) A statement generally describing the health maintenance organization, its health care plans, facilities, and personnel;
 - (6) A copy of the form of evidence of coverage to be issued to the enrollees;
 - (7) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;
 - (8)(A) Financial statements showing the applicant's assets, liabilities, and sources of

financial support.

- (B) If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement, unless the commissioner directs that additional or more recent financial information is required for the proper administration of this chapter;
 - (9) A financial feasibility plan which includes:
 - (A) Detailed enrollment projections;
 - (B) The methodology for determining premium rates to be charged during the first twelve (12) months of operation certified by an actuary or other qualified person;
 - (C) A projection of balance sheets;
 - (D) Cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one (1) year; and
 - (E) A statement as to the source of working capital as well as any other sources of funds;
 - (10)(A) On and after January 1, 2003, a power of attorney executed by the applicant, if not domiciled in this state, and filed, along with a proper fee specified by the commissioner, with the commissioner's office to register an Arkansas resident to serve as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served.
 - (B) In the event no registered agent has been chosen, the commissioner may be served until the appointment of an Arkansas registered agent for service of process has been entered upon the records of the commissioner;
 - (11) A statement or map reasonably describing the geographic areas to be served;
 - (12) A description of the complaint procedures to be utilized as required under § 23-76-116;
 - (13) A description of the procedures and programs to be implemented to meet the quality of health care requirements in § 23-76-108(a)(2);
 - (14) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under § 23-76-110(b);
 - (15) A list of the names and addresses of all providers with which the health maintenance organization has agreements; and
 - (16) Such other information as the commissioner may require to make the determinations required in § 23-76-108.
- (d)(1) A health maintenance organization shall file a notice describing any major modification of the operation set out in the information required by subsection (c) of this section, unless otherwise provided for in this chapter. The notice shall be filed with the commissioner prior to the modification. If the commissioner does not disapprove within sixty (60) days of filing, the modification shall be deemed

approved.

- (2) The commissioner shall promulgate rules and regulations exempting from the filing requirements of subdivision (c)(1) of this section those items the commissioner deems unnecessary.

23-76-108. Issuance of certificate of authority.

- (a)(1) Upon receipt of an application for issuance of a certificate of authority, the Insurance Commissioner shall immediately transmit copies of the application and accompanying documents to the Director of the Department of Health.
- (2) The director shall determine whether the applicant for a certificate of authority with respect to health care services to be furnished:
 - (A) Has demonstrated the legal qualifications and authority and potential ability to assure that the health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability and accessibility and continuity of service;
 - (B) Has arrangements, established in accordance with regulations promulgated by the director for an ongoing quality of health care assurance program concerning health care processes and outcomes; and
 - (C) Has a procedure established in accordance with regulations of the director to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and other matters as may be reasonably required by the director.
- (3)(A) Within sixty (60) days of receipt of the application for issuance of a certificate of authority, the director shall certify to the commissioner whether the proposed health maintenance organization meets the requirements of subdivision (a)(2) of this section.
 - (B) If the director certifies that the health maintenance organization does not meet the requirements, he shall specify in what respects it is deficient. However, the director shall not certify that the requirements are not met unless the proposed health maintenance organization has been given an opportunity to comment on the proposed findings of deficiency.
 - (C) If requested by the proposed health maintenance organization, the director shall hold a hearing on his proposed finding of deficiency.
- (b) The commissioner shall issue a certificate of authority to any person filing an application pursuant to § 23-76-107 within sixty (60) days of receipt of the certificate from the director, when the commissioner is satisfied that the following conditions are met:
 - (1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;
 - (2) The director certifies in accordance with subsection (a) of this section that the health maintenance organization's proposed plan of operation meets the requirements of subdivision (a)(2) of this section;
 - (3) The health care plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of

- basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments;
- (4) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees;
 - (5) The health care plan's arrangements for health care services and the schedule of charges for use therewith are financially sound and reasonable;
 - (6) Any agreements with insurers, hospitals, medical service corporations, governmental entities, or any other organizations for insuring the payment of the cost of health care services or the provision for automatic applicability of alternative coverage in the event of discontinuance of the plan are reasonable and adequate;
 - (7) Agreements with providers for the provision of health care services are reasonable and adequate;
 - (8) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to § 23-76-110;
 - (9) Nothing in the proposed method of operation, as shown by the information submitted pursuant to § 23-76-107 or by independent investigation is contrary to the public interest;
 - (10) Any deficiencies certified by the director have been corrected;
 - (11) Any deposit of cash or securities, in an amount determined to be appropriate by the commissioner pursuant to § 23-76-118, is sufficient to guarantee that the obligations to provide the promised benefits will be performed; and
 - (12) The applicant has paid-in capital in an amount not less than one hundred thousand dollars (\$100,000) and additional working capital or surplus funds in an amount deemed by the commissioner to be adequate in relation to the proposed plan of operation.
- (c) A certificate of authority shall be denied only after compliance with the requirements of § 23-76-126.

23-76-109. Powers.

- (a) The powers of a health maintenance organization include, but are not limited to, the following:
- (1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and the property as may reasonably be required for its principal office or for other purposes as may be necessary in the transaction of the business of the organization;
 - (2) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees;
 - (3) The furnishing of health care services through providers which are under contract

- with the health maintenance organization;
- (4) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;
 - (5) The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;
 - (6) The offering, in addition to basic health care services, of:
 - (A) Additional health care services;
 - (B) Indemnity benefits covering out-of-area or emergency services, and special services not provided on a direct service basis; and
 - (C)(i) Indemnity benefits on a point-of-service basis within such limits as may be prescribed by the Insurance Commissioner.
 - (ii) As used herein, the term "point-of-service" means indemnifying or paying on behalf of an enrollee for covered health care services on a nonemergency, self-referred basis obtained from providers who are not employed by, under contract with, or otherwise affiliated with, the health maintenance organization, or services obtained from providers affiliated with the health maintenance organization without proper referrals; and
 - (7) The contracting with providers located out of state who are properly licensed to render medical care in the jurisdiction in which such provider is located.
- (b)(1) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to each exercise of any power granted in subdivisions (a)(1) or (2) of this section. The commissioner shall disapprove the exercise of power if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove within sixty (60) days of the filing, it shall be deemed approved.
- (2) The commissioner may promulgate rules and regulations exempting from the filing requirement of subdivision (b)(1) of this section those activities having a de minimis effect.

23-76-110. Governing body.

- (a) The governing body of any health maintenance organization shall include at least one (1) physician, one (1) dentist, one (1) pharmacist, one (1) nurse, one (1) consumer, and one (1) enrollee.
- (b) The governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

23-76-111. Fiduciary responsibilities of director, officer, or partner.

- (a) Any director, officer, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the

organization shall be responsible for the funds in a fiduciary relationship to the enrollees.

- (b) A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on these employees, officers, directors, and partners in an amount not less than two hundred fifty thousand dollars (\$250,000) for each health maintenance organization or a maximum of five million dollars (\$5,000,000) in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or the sum prescribed by the Insurance Commissioner.

23-76-112. Evidence of coverage and charges for health care services.

- (a)(1) Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a hospital and medical service corporation, whether by option or otherwise, the insurer or the hospital and medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.
- (2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the Insurance Commissioner.
- (3) An evidence of coverage shall contain:
- (A) No provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive; which encourage misrepresentation; or which are untrue, misleading, or deceptive as defined in § 23-76-119; and
 - (B) A clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:
 - (i) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;
 - (ii) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;
 - (iii) Where and in what manner information is available as to how services may be obtained;
 - (iv) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates; and
 - (v) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee.
- (4) A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, shall be subject to the filing and approval requirements of subdivision (a)(2) of this section unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or hospital or medical service corporations in which event the filing and approval provisions of the laws shall apply. To the extent, however, that the provisions do not apply, the

- requirements in subdivision (a)(3) of this section shall be applicable.
- (b)(1) No schedule of charges for enrollee coverage for health care services, or amendment thereto, may be used in conjunction with any health care plan until either a copy of the schedule, or the methodology for determining charges has been filed with and approved by the commissioner.
- (2)(A) Either a specific schedule of charges or a methodology for determining charges shall be established in accordance with the actuarial principles for various categories of enrollees, provided that charges applicable to an individual enrollee in a group contract shall not be individually determined based on the status of the enrollee's health. However, the charges shall not be excessive, inadequate, or unfairly discriminatory.
- (B) A certification by a qualified actuary, to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.
- (c)(1)(A) Within a reasonable period, the commissioner shall approve any form if the requirements of subsection (a) of this section are met and any schedule of charges or methodology for determining charges if the requirements of subsection (b) of this section are met.
- (B) It shall be unlawful to issue the form or to use the schedule of charges or methodology for determining charges until approved.
- (2) If the commissioner disapproves the filing, he or she shall notify the filer promptly. In the notice, the commissioner shall specify the reasons for disapproval and the findings of fact and conclusion which support the reasons. A hearing will be granted by the commissioner within sixty (60) days after a request in writing by the person filing. If the commissioner does not disapprove any form or schedule of charges within sixty (60) days of the filing of the forms or charges, they shall be deemed approved.
- (3) If the commissioner disapproves any form or schedule of charges or methodology for determining charges, the commissioner's disapproval and the findings of fact and conclusions which support the commissioner's reasons shall be subject to judicial review pursuant to § 23-61-307. The review shall be upon the entire record, and the commissioner's decision shall be sustained if it is supported by the preponderance of the evidence in the record.
- (d) The commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

23-76-113. Annual report and quarterly report.

- (a) Every health maintenance organization shall annually, on or before March 1, file a report verified by at least two (2) principal officers with the Insurance Commissioner, with a copy to the Director of the Department of Health, covering the preceding calendar year.
- (b)(1) The report shall be on forms prescribed by the commissioner.
- (2) For the report to be filed March 1, 2002, and annually thereafter, the annual report prescribed by the commissioner shall be the current edition, published by

- the National Association of Insurance Commissioners, of the "Annual Statement Blank For Health", which shall be prepared in accordance with the National Association of Insurance Commissioners' "Annual Statement Instructions For Health" and shall follow those accounting practices and procedures prescribed and published in the current edition of the National Association of Insurance Commissioners' "Accounting Practices and Procedures Manual".
- (3) Each authorized health maintenance organization shall furnish all information as called for by the National Association of Insurance Commissioners' "Annual Statement Blank For Health". Further, it shall be verified by oath or affirmation of the health maintenance organization's president or vice president and secretary or actuary.
 - (4) The commissioner shall furnish to each domestic health maintenance organization two (2) copies of the forms on which the annual statement is to be made.
 - (5) The annual report shall include:
 - (A) An annual audited financial report certified by an independent certified public accountant;
 - (B) Any material changes in the information submitted pursuant to § 23-76-107(c);
 - (C) The number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year;
 - (D) A summary of information compiled pursuant to § 23-76-108 in such form as required by the director; and
 - (E) Any other information on an annual, quarterly, or more frequent basis as the commissioner shall prescribe, relating to the performance of the health maintenance organization, which is necessary to enable the commissioner to carry out his or her duties under this chapter.
- (c) Any health maintenance organization that fails to file the annual, quarterly, or any required financial or other report when due may be subject to a penalty of one hundred dollars (\$100) for each day of delinquency in the commissioner's discretion, or unless the penalty is waived by the commissioner upon a showing of good cause by the organization.
- (d)(1)(A) Beginning on and after January 1, 2000, each authorized health maintenance organization shall prepare and file with the commissioner a quarterly financial report on forms and at such times as shall be prescribed by the commissioner.
- (B) For the reports to be filed January 1, 2002, and quarterly reports thereafter, the quarterly financial report shall be the current edition, published by the National Association of Insurance Commissioners, of the "Quarterly Statement Blank For Health", which shall be prepared in accordance with the National Association of Insurance Commissioners' "Quarterly Statement Instructions For Health" and shall follow those accounting procedures and practices prescribed by the National Association of Insurance Commissioners' "Accounting Practices And Procedures Manual".
- (2) The quarterly statement shall be verified by the officers of the health maintenance

organization as required by the current edition, published by the National Association of Insurance Commissioners, of the quarterly statement instructions as a companion to the reporting form prescribed by the commissioner.

23-76-114. Information to enrollees.

- (a) A health maintenance organization shall make available to its subscribers a list of providers upon enrollment and re-enrollment.
- (b) Every health maintenance organization shall provide within thirty (30) days to its subscribers a notice of any material change in the operation of the organization, including any major change in its provider network, that will affect them directly.
- (c)(1) An enrollee shall be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee.
- (2) The health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.
- (d) The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services can be obtained, and a telephone number where the enrollee can contact the health maintenance organization, at no cost to the enrollee.

23-76-115. Open enrollment.

- (a)(1) After a health maintenance organization has been in operation twenty-four (24) months, it shall have an annual open enrollment period of at least one (1) month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment.
- (2) A health maintenance organization may apply to the Insurance Commissioner for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services.
- (3) The commissioner shall approve or deny the application within sixty (60) days of its receipt from the health maintenance organization.
- (b) Health maintenance organizations providing or arranging for services on a group contract basis may limit the open enrollment provided for in subsection (a) of this section to all members of the groups covered by the contracts.

23-76-116. Complaint system.

- (a)(1) Every health maintenance organization shall establish and maintain a complaint system which has been approved by the Insurance Commissioner after consultation with the Director of the Department of Health to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.
- (2) Each health maintenance organization shall submit to the commissioner and the director an annual report in a form prescribed by the commissioner, after consultation with the director, which shall include:

- (A) A description of the procedures of such complaint system;
 - (B) The total number of complaints handled through such complaint system and a compilation of causes underlying the complaints filed; and
 - (C) The number, amount, and disposition of malpractice claims settled during the year by the health maintenance organization.
- (b) The health maintenance organization shall maintain records of written complaints filed with it concerning other than health care services and shall submit to the commissioner a summary report at such times and in such format as the commissioner may require. Complaints involving other persons shall be referred to the persons with a copy to the commissioner.
 - (c) The commissioner or the director may examine the complaint system, subject to the limitation concerning medical records of individuals set forth in § 23-76-122(c).

23-76-117. Investments.

With the exception of investments made in accordance with § 23-76-109(a)(1), (a)(2) and (b), the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this state for the investment of assets constituting the legal reserves of life insurance companies or other securities or investments as the Insurance Commissioner may permit.

23-76-118. Protection against insolvency.

(a) Deposit Requirements.

- (1)(A) All health maintenance organizations authorized to transact business in this state shall deposit through the Insurance Commissioner securities eligible for deposit under § 23-63-903 which at all times shall have a par or market value of not less than three hundred thousand dollars (\$300,000), with the exception of limited benefit health maintenance organizations whose security deposit shall not be less than one hundred thousand dollars (\$100,000).
- (B) The commissioner shall also be authorized to require a special surplus deposit for the benefit of enrollees from each health maintenance organization.
- (2) All deposits made through the commissioner and held in this state shall be subject to the applicable provisions of §§ 23-63-903 - 23-63-907, 23-63-910, and 23-63-911 which refer to administration of deposits.
- (3)(A)(i) A health maintenance organization, excluding limited benefit health maintenance organizations, that is in operation on August 1, 1997, shall make a deposit equal to one hundred fifty thousand dollars (\$150,000).
 - (ii) In the second year, the amount of the additional deposit for a health maintenance organization that is in operation August 1, 1997, shall be equal to one hundred fifty thousand dollars (\$150,000), for a total of three hundred thousand dollars (\$300,000).
- (B)(i) A limited benefit health maintenance organization that is in operation on August 1, 1997, shall make a deposit equal to seventy-five thousand dollars (\$75,000).

- (ii) In the second year, the amount of the additional deposit for a limited benefit health maintenance organization that is in operation on August 1, 1997, shall be equal to twenty-five thousand dollars (\$25,000) for a total of one hundred thousand dollars (\$100,000).
- (4) The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.
- (5)(A) The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization that is in rehabilitation or conservation.
 - (B) The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation.
 - (C) If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the Uniform Insurers Liquidation Act, § 23-68-101 et seq.
- (b)(1)(A) No participating provider or the provider's agent, trustee, or assignee may maintain an action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization nor make any statement, either written or oral, to any subscriber or enrollee that makes demand for, or would lead a reasonable person to believe that a demand is being made for, payment of any amounts owed by the health maintenance organization.
 - (B)(i) If a participating provider has a pattern or practice of violating this subsection and continues to violate this subsection after the Insurance Commissioner has issued a written warning to the participating provider, the commissioner may levy a penalty in an amount not less than one hundred fifty dollars (\$150) nor more than one thousand five hundred dollars (\$1,500).
 - (ii) Before imposing the penalty, the commissioner shall send a written notice to the participating provider informing the provider of the right to a hearing pursuant to §§ 23-61-303 - 23-61-307.
- (2) "Participating provider" means a "provider" as defined in § 23-76-102(10) who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.
- (c) **Continuation of Benefits.** The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the commissioner may require:
 - (1) Insurance to cover the expenses to be paid where date of services precedes the premium paid for it;
 - (2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge

- from inpatient facilities;
- (3) Insolvency reserves;
 - (4) Acceptable letters of credit; and
 - (5) Any other arrangements to assure that benefits are continued as specified above.

23-76-119. Prohibited practices.

- (a) No health maintenance organization, or representative thereof, may knowingly cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this chapter:
 - (1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan;
 - (2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and
 - (3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing the evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.
- (b) An enrollee may not be cancelled or nonrenewed except for the failure to pay the charge for the coverage or for such other reasons as may be promulgated by the Insurance Commissioner.
- (c) **Hold Harmless.**
 - (1) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.
 - (2) In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.
 - (3)(A) No participating provider or the provider's agent, trustee, or assignee may

maintain an action at law against a subscriber or enrollee to collect sums owed to them by the health maintenance organization nor shall they make any statement, either written or oral, to any subscriber or enrollee that makes demand for, or would lead a reasonable person to believe that a demand is being made for, payment of any amounts owed by the health maintenance organization.

(B)(i) If a participating provider has a pattern or practice of violating this subsection and continues to violate this subsection after the commissioner has issued a written warning to the participating provider, the commissioner may levy a penalty in an amount not less than one hundred fifty dollars (\$150) nor more than one thousand five hundred dollars (\$1,500).

(ii) Before imposing the penalty, the commissioner shall send a written notice to the participating provider informing the provider of the right to a hearing pursuant to § 23-61-303 - 23-61-307.

(4) "Participating provider" means a "provider" as defined in § 23-76-102(10) who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.

23-76-120. Regulation of agents.

- (a) The Insurance Commissioner may, after notice and hearing, promulgate such reasonable rules and regulations as are necessary to provide for the licensing of agents.
- (b) "Agent" means a person directly or indirectly associated with a health care plan who engages in solicitation or enrollment.

23-76-121. Powers of insurers and hospital and medical service corporations.

- (a) An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly, or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter.
- (b)(1) Notwithstanding any provision of the Hospital and Medical Service Corporations Act, chapter 75 of this title, an insurer or a hospital and medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations.
 - (2) The enrollees of a health maintenance organization constitute a permissible group under such laws.
 - (3) Among other things, under the contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to the health plan.

23-76-122. Examinations.

- (a) The Insurance Commissioner may make an examination of the affairs of any health maintenance organization as often as he or she deems it necessary for the protection of the interests of the people of this state but not less frequently than once every three (3) years.
- (b) The Director of the Department of Health may make an examination concerning the quality of health care services of any health maintenance organization as often as he or she deems it necessary for the protection of the interests of the people of this state but not less frequently than once every three (3) years.
- (c)(1) Every health maintenance organization shall submit its books and records relating to the health care plan to the examinations and in every way facilitate them.
- (2) For the purpose of examinations, the commissioner and the director may administer oaths to and examine the officers and agents of the health maintenance organization.
- (3) Medical records of individuals and records of physicians and hospitals providing services under a contract to the health maintenance organization shall be subject to the examination.
- (d) The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner or the director for whom the examination is being conducted.
- (e) In lieu of the examination, the commissioner or the director may accept the report of an examination made by the commissioner or director of the department of health of another state.
- (f)(1) Any examination under this section that is to commence within one (1) year prior to the date a health maintenance organization shall cease to provide health care services in this state, may be reduced in scope or waived in its entirety, upon application of the health maintenance organization and approval of the commissioner.
- (2) The commissioner shall consider the following in determining whether a full or partial waiver may be granted:
 - (A) Claims payment history;
 - (B) Consumer complaint history with the department;
 - (C) Financial condition; and
 - (D) Compliance with § 23-76-118.
- (3) Any health maintenance organization requesting a waiver of an examination shall continue to comply with § 23-76-118 until such time as it is no longer providing health care services in this state.

23-76-123. Suspension or revocation of certificate of authority.

- (a) The Insurance Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this chapter if he finds that any of the following conditions exist:
 - (1) The health maintenance organization is operating in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under § 23-76-107, unless amendments to the submissions have been filed with and

- approved by the commissioner;
- (2) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of § 23-76-112;
 - (3) The health care plan does not provide or arrange for basic health care services;
 - (4) The Director of the Department of Health certifies to the commissioner that:
 - (A) The health maintenance organization does not meet the requirements of § 23-76-108(a)(2); or
 - (B) The health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its health care plan;
 - (5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;
 - (6) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under § 23-76-110;
 - (7) The health maintenance organization has failed to implement the complaint system required by § 23-76-116 in a manner to reasonably resolve valid complaints;
 - (8) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;
 - (9) The continued operation of the health maintenance organization would be hazardous to its enrollees; or
 - (10) The health maintenance organization has otherwise failed to substantially comply with this chapter.
- (b) A certificate of authority shall be suspended or revoked only after compliance with the requirements of § 23-76-126.
- (c) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation whatsoever.
- (d)(1) When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs. It shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever.
- (2) The commissioner may, by written order, permit the further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

23-76-124. Rehabilitation, liquidation, or conservation of health maintenance organization.

- (a) Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the Insurance Commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies.
- (b) The commissioner may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one (1) or more grounds set out in § 23-68-107 or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state.

23-76-125. Regulations.

- (a) The Insurance Commissioner may, after notice and hearing, promulgate reasonable rules and regulations, not inconsistent with existing statutes of this state, as are necessary or proper to carry out the provisions of this chapter.
- (b) The rules and regulations shall be subject to review in accordance with § 23-61-307.

23-76-126. Administrative proceedings.

(a) Application for a Certificate of Authority.

- (1) The public hearing referred to in § 23-76-108(a)(3)(C) shall be held within sixty (60) days after receipt by the Insurance Commissioner of the certification from the Director of the Department of Health, and at least twenty (20) days' notice thereof shall be given by the commissioner to the person filing the application.
- (2) At the hearing, the person filing the application, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the courts of this state.
- (3) All discovery proceedings shall be concluded not later than three (3) days prior to commencement of the public hearing.

(b) Proceedings Against a Certificate of Authority.

- (1) When the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization and the director in writing specifically stating the grounds for suspension or revocation and fixing a time of at least twenty (20) days thereafter for a hearing on the matter.
- (2)(A) The director, or his designated representative, shall be in attendance at the hearing and shall participate in the proceedings.
- (B) The recommendation and findings of the director, with respect to matters relating to the quality of health care services provided in connection with any decision regarding suspension or revocation of a certificate of authority, shall be conclusive and binding upon the commissioner.
- (C) After the hearing or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall take action as is deemed

advisable on written findings which shall be mailed to the health maintenance organization with a copy thereof to the director.

- (c) **Judicial Review.** The action of the commissioner and the recommendation and findings of the director shall be subject to review by the Circuit Court of Pulaski County. The court may, in disposing of the issue before it, affirm or reverse the order of the commissioner. The review shall be upon the entire record and the commissioner's decision shall be affirmed if it is supported by the preponderance of the evidence in the record.
- (d) The provisions of the Arkansas Administrative Procedure Act, § 25-15-201 et seq., shall apply to proceedings under this section to the extent they are not in conflict with subsections (a) and (b) of this section.

23-76-127. Fees - Disposition of revenues.

- (a) Every health maintenance organization subject to this chapter shall pay the Department of Health the following fees:
 - (1) For filing, reviewing, and issuance of all documents necessary for the issuance of the original certificate of authority, one thousand dollars (\$1,000);
 - (2) For annual renewal of the certificate of authority, five hundred dollars (\$500);
 - (3) For filing an annual statement, fifty dollars (\$50.00); and
 - (4) For filing amendments to documents required under § 23-76-107(c)(2), twenty-five dollars (\$25.00).
- (b)(1) All fees levied and collected under this section are declared to be special revenues and shall be deposited in the State Treasury, there to be credited to the Public Health Fund.
- (2) Subject to such rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the Department of Health is authorized to transfer all unexpended funds relative to the health maintenance organization that pertain to fees collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.
- (c) Every health maintenance organization subject to this chapter shall pay to the State Insurance Department Trust Fund as special revenues the following fees:
 - (1) For filing and reviewing all documents necessary for issuance of an original certificate of authority, one thousand dollars (\$1,000);
 - (2) For issuance of the original certificate of authority, two hundred dollars (\$200);
 - (3) For annual renewal of the certificate of authority, one hundred dollars (\$100);
 - (4) For filing an annual statement, fifty dollars (\$50.00); and
 - (5) For filing amendments to documents required under § 23-76-107, one hundred dollars (\$100).

23-76-128. Applications, filings, and reports public.

All applications, filings, and reports required under this chapter shall be treated as public documents.

23-76-129. Medical information confidential - Exceptions.

- (a) Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from the person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter, upon the express consent of the enrollee or applicant, pursuant to statute or court order for the production of evidence or the discovery thereof or in the event of claim of litigation between the person and the health maintenance organization wherein the data or information is pertinent.
- (b) A health maintenance organization shall be entitled to claim any statutory privileges against the disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

23-76-130. Director of the Department of Health's authority to contract.

- (a) The Director of the Department of Health, in carrying out his obligations under §§ 23-76-108(a)(2), 23-76-122(b), and 23-76-123(a), may contract with qualified persons to make recommendations concerning the determinations required to be made by him.
- (b) The recommendations may be accepted in full or in part by the director.

23-76-131. Tax on premiums and copayments.

- (a)(1) Each health maintenance organization shall pay a tax on the premiums for coverages provided during the calendar year. The tax shall be paid on an annual basis and on a quarterly estimate basis as prescribed by the Insurance Commissioner and reconciled at the time of filing the annual statement. The taxes due from licensed health maintenance organizations under this section shall be computed on net direct written premiums at the rate described in this section and in §§ 26-57-603 and 26-57-604. Further, the premium taxes at the same rate due under this section for health maintenance organization copayments shall only be computed, reported, and paid on the copayments actually received and collected by the health maintenance organization. Copayments paid by the patient directly to the doctor, hospital, or other medical providers shall not be subject to taxation.
 - (2) The tax shall be paid to the Treasurer of State through the commissioner as a tax imposed for the privilege of transacting business in this state. The tax shall be computed at the rate of two and one-half percent (2 1/2%), except as provided in subsection (b) of this section;
 - (3) The taxes shall be paid on a quarterly estimate basis as prescribed by the commissioner and reconciled annually at the time of filing the annual statement. In his discretion, the commissioner may suspend or revoke the certificate of authority of any health maintenance organization that fails to pay the tax levied under this section on the date due or during any reasonable extension of time therefor which may have been expressly granted by the commissioner for good cause upon the organization's request.
- (b)(1) For health maintenance organizations maintaining a home office or a regional office in this state, the tax shall be computed at the rate of two and one-half percent

(21/2%), except for the credit as provided in § 26-57-604. For purposes of this subsection, any office in this state shall be deemed an organization's home or regional office if the office performs substantially the following functions in this state:

- (A) Underwriting;
 - (B) Medical;
 - (C) Legal;
 - (D) Issuance of certificates or contracts;
 - (E) Claims servicing, information, and service;
 - (F) Advertising and publications;
 - (G) Public relations;
 - (H) Hiring, testing, and training of sales or service forces.
- (2) On or before March 1 of each year, any health maintenance organization desiring to qualify an office in this state as a home or regional office shall furnish to the commissioner on forms prescribed by the commissioner proof that it is operating a home or regional office in this state.
- (c) The commissioner shall deposit all taxes collected under this section in the State Treasury as general revenues.

23-76-132. College students.

If a health maintenance organization requires the selection or assignment of a primary care physician, the health maintenance organization shall provide an enrollee who is a student enrolled at a postsecondary institution one (1) of the following options:

- (1) To select two (2) primary care physicians, one (1) located near the enrollee's domicile and one (1) located near the postsecondary institution, provided both primary care physicians have provider contracts with the health maintenance organization; or
- (2) To select a primary care physician when the enrollee resides near the enrollee's domicile and then change primary care physicians when the enrollee attends the postsecondary institution, the effective date of the change to be the first of the month following notification, provided both primary care physicians have provider contracts with the health maintenance organization.