

Chapter 79. Insurance Policies Generally.

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Subchapter 1. General Provisions.

23-79-101. Definitions.

As used in §§ 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, unless the context otherwise requires:

- (1) "Policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements, and papers made a part thereof; and
- (2) "Premium" is the consideration for insurance, by whatever name called. Any assessment, or any membership, policy, survey, inspection, service, or similar fee or charge in consideration for a policy is deemed part of the premium.

23-79-102. Scope.

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 shall not apply as to:

- (1) Reinsurance;
- (2)(A) Policies or contracts not issued for delivery in this state nor delivered in this state, except upon subjects of insurance, other than life or accident and health insurance, located or to be performed in this state and except as provided in § 23-79-109(e), approval of forms for delivery in jurisdictions where local approval not provided for.
(B) Subdivision (2)(A) of this section shall not apply to group insurance certificates issued under group insurance policies effectuated and delivered outside this state but covering persons resident in this state;
- (3) Wet marine and foreign trade insurance; and
- (4) Title insurance, except as to the following provisions:
 - (A) Section 23-79-109, filing, approval of forms;
 - (B) Section 23-79-110, grounds for disapproval;
 - (C) Section 23-79-113, charter, bylaw provisions;
 - (D) Section 23-79-116, execution of policies;
 - (E) Section 23-79-119, construction of policies; and
 - (F) Sections 23-79-202 - 23-79-205 and 23-79-208, suits against insurers, etc.

23-79-103. Insurable interest - Personal insurance.

- (a) Any individual of competent legal capacity may procure or effect an insurance contract upon his own life or body for the benefit of any person. However, no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under the contract are payable to the individual insured or his personal representatives, or to a person having, at the time when the contract was made, an insurable interest in the individual insured.
- (b) If the beneficiary, assignee, or other payee under any contract made in violation of this section receives from the insurer any benefits thereunder accruing upon the death,

disablement, or injury of the individual insured, the individual insured or his executor or administrator, as the case may be, may maintain an action to recover the benefits from the person so receiving them.

- (c)(1) "Insurable interest" with reference to personal insurance includes only interests as follows:
- (A) In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection;
 - (B) In the case of other persons, a lawful and substantial economic interest in having the life, health, or bodily safety of the individual insured continue, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement, or injury of the individual insured;
 - (C) An individual party to a contract or option for the purchase or sale of an interest in a business partnership or firm, or of shares of stock of a closed corporation or of an interest in such shares, as an insurable interest in the life of each individual party to the contract and for the purposes of the contract only, in addition to any insurable interest which may otherwise exist as to the life of the individual; and
 - (D) A publicly owned corporation has an insurable interest in the lives of any of its directors, officers, and employees.
- (2)(A) Notwithstanding any other law or regulation to the contrary, any religious, educational, charitable, or benevolent institution, organization, corporation, association, or trust, including, but not limited to, charitable remainder trusts, may be named beneficiary and/or owner of the policy or contract by any applicant for insurance upon his or her own life in any policy of life insurance issued by any life insurance company authorized to do business in this state or in the state of domicile of the applicant for insurance.
- (B) The applicant for insurance shall be deemed to have an unlimited insurable interest in his or her own life, and is entitled to name any of said institutions as beneficiary of such insurance, and said beneficiaries and/or owners shall have the right to receive all death benefits provided for by such policies and to exercise the rights of ownership if granted same.
 - (C) As to any life insurance policies heretofore issued by insurers naming any of the aforementioned institutions as beneficiaries and/or owners, if the applicant for insurance was also the insured, the beneficiaries or owners shall be entitled to receive all death benefits provided by the policy and to exercise the rights of ownership if granted same.

23-79-104. Insurable interest - Property.

- (a) No contract of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured at the time of the effectuation of the insurance and at the time of the loss.
- (b) "Insurable interest" as used in this section means any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free

from loss, destruction, or pecuniary damage or impairment.

23-79-105. Application required - Life and accident and health insurance.

No life or accident and health insurance contract upon an individual, except a contract of group life insurance or of group or blanket accident and health insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefor or has consented thereto in writing, except in the following cases:

- (1) A spouse may effectuate the insurance upon the other spouse;
- (2) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effectuate insurance upon the life of, or pertaining to, the minor;
- (3) The application for accident insurance procured through a vending machine licensed under § 23-64-221 must be signed by the individual to be so insured or, if the individual to be so insured does not have legal capacity to contract, the application must be signed by the individual's parent, guardian, or other legally constituted representative; and
- (4) Family policies may be issued insuring any two (2) or more members of a family on an application signed by either parent, a stepparent, or by a husband or wife.

23-79-106. Application - Use as evidence - Alteration.

- (a) No application for the issuance of any life or accident and health insurance policy or annuity contract shall be admissible in evidence in any action relative to the policy or contract, unless a true copy of those portions of the application signed by the applicant was attached to, or otherwise made a part of, the policy or contract when issued.
- (b)
 - (1) If any policy of life or accident and health insurance delivered in this state is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for reinstatement or renewal, the insurer, within thirty (30) days after receipt of the request at its home office or at any of its branch offices, shall deliver or mail to the person making the request a copy of the application.
 - (2) If the copy is not delivered or mailed after having been requested, the insurer shall be precluded from introducing the application in evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal.
 - (3) In the case of a request from a beneficiary, the time within which the insurer is required to furnish a copy of the application shall not begin to run until after receipt of evidence satisfactory to the insurer of the beneficiary's vested interest in the policy or contract.
- (c) No alteration of any written application for any life or accident and health insurance policy shall be made by any person other than the applicant without his or her written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that the insertions are not to be ascribed to the applicant.

23-79-107. Application - Statements as representations.

- (a) All statements in any application for a life or accident and health insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:
- (1) Fraudulent;
 - (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or
 - (3) The insurer in good faith would not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the facts had been made known to the insurer as required by the application for the policy or contract or otherwise.
- (b) In any action to rescind any policy or contract or to recover thereon, if any misrepresentation with respect to a medical impairment is proved by the insurer and the insured or any other person having or claiming a right under the contract shall prevent full disclosure and proof of the nature of the medical impairment, then the misrepresentation shall be presumed to have been material.
- (c) In any action to rescind any policy or contract or to recover thereon, a misrepresentation is material if there is a causal relationship between the

23-79-108. Return of premium to rejected applicant.

After an insurer rejects or declines to issue a life or accident and health insurance policy, the insurer shall return the premium to the applicant within a reasonable period of time.

23-79-109. Filing and approval of forms.

- (a)(1)(A) No basic insurance policy, or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, shall be issued, delivered, or used as to a subject of insurance resident, located, or to be performed in this state unless the form has been filed with and approved by the Insurance Commissioner and, in the case of individual accident and health contracts, the rates have been filed with and approved by the commissioner.
- (B) This subsection shall not apply to policy or coverage forms for large commercial risks, as defined in subsection (g) of this section, commercial umbrella policy or coverage forms, excess umbrella policy or coverage forms, excess of loss policy or coverage forms, public officials' liability policy or coverage forms, fiduciary liability policy or coverage forms, directors' and officers' liability policy or coverage forms, kidnap and ransom policy or coverage forms, political risk policy or coverage forms, expropriation coverage policy or coverage forms, mortgage pool insurance policy or coverage forms, railroad protective liability policy or coverage forms, equity loan programs (second mortgage coverage) policy or coverage forms, highly protected risk forms, or surety bonds, nor to policies, orders, endorsements, or

forms of unique character designed for, and used with relation to, insurance upon a particular subject, or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life and accident and health insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder.

- (C) The exemption of a particular type of insurance policy form from the requirement that it be filed with the commissioner and expressly approved thereby is not to be taken by an insurer as meaning that any insurance effected by the use of such form may in any fashion be inconsistent with the statutory and common law of this state which is properly applicable thereto.
- (2) As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with and approved by the commissioner.
- (3) No group accident and health certificate of insurance may be extended to residents of this state under a group accident and health policy issued outside this state which does not include the provisions required for group policies issued in this state, unless the commissioner determines that the provisions are not appropriate for the coverage provided. Upon request of the commissioner, copies of such group accident and health policies issued outside this state shall be made available on an informational basis.
- (4) On and after January 1, 1990, all medicare supplement rates shall be based on a composite age basis only, and shall not be based on any age banding or other groupings.
- (5) Nothing in this subsection shall prohibit an insurer or hospital and medical service corporation issuing medicare supplement insurance policies from using its usual and customary underwriting procedures or excluding preexisting health conditions; provided, that no insurer shall refuse to issue a medicare supplement policy based solely on the age of the applicant.
- (b)(1) Every filing shall be made not less than thirty (30) days in advance of any delivery. At the expiration of the thirty (30) days, the form or rate so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by the commissioner.
- (2) Approval of the form or rate by the commissioner shall constitute a waiver of any unexpired portion of the waiting period.
- (3) The commissioner may extend by not more than an additional thirty (30) days the period within which he or she may so affirmatively approve or disapprove the form or rate by giving notice of the extension before expiration of the initial thirty-day period.
- (4) At the expiration of the period as so extended, and in the absence of prior affirmative approval or disapproval, the form or rate shall be deemed approved.
- (5) The commissioner may at any time, after notice and for cause shown, withdraw approval.
- (c) Notification disapproving the form or withdrawing a previous approval shall state the grounds therefor.

- (d) By order, the commissioner may exempt from the requirements of this section, for so long as he or she deems proper, any insurance document or form or type thereof as specified in the order to which, in his or her opinion, this section may not practically be applied or the filing and approval of which are, in his or her opinion, not desirable or necessary for the protection of the public.
- (e) This section shall apply also to any form used by domestic insurers for delivery in a jurisdiction outside this state, if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by that official, and upon the commissioner's written notice requiring the form to be submitted to him or her for the purpose. The same standards which are applicable to forms for domestic use shall apply to such forms.
- (f) No policy or contract form providing coverage for personal automobile liability which provides for a policy term of less than six (6) months shall be approved by the commissioner or issued for delivery in this state and used by insurers on and after January 1, 1992. However, the provisions of this subsection shall not restrict premium payment options offered by insurers.
- (g)(1) For purposes of this section, "large commercial risk" means an insured that has:
 - (A) A total premium of two hundred fifty thousand dollars (\$250,000) or more for property and casualty insurance;
 - (B) At least twenty-five (25) full-time employees; and
 - (C) A full-time certified risk manager to procure property and casualty insurance. For purposes of this subsection, "certified risk manager" shall mean a risk manager with one (1) or more of the following credentials:
 - (i) Associate in risk management;
 - (ii) Chartered property casualty underwriter; or
 - (iii) Certified risk manager.
- (2) The exemption for "large commercial risk" policy or coverage forms set forth in subdivision (a)(1) of this section shall not apply to workers' compensation, employers' liability or professional liability insurance, including, but not limited to, medical malpractice insurance.
- (3)(A) In procuring coverage, a large commercial risk shall certify that it:
 - (i) Meets the eligible criteria for an exempt commercial policyholder set out in this subsection;
 - (ii) Is aware that the policy is unregulated for rates and forms; and
 - (iii) Has the necessary expertise to negotiate its own policy language.
- (B) This certification shall be completed annually and remain on file with the producing agent or broker.
- (h) If the commissioner deems that the review as to either rates or forms, or both, required by this section as to any particular line or lines of insurance, can be performed in some other manner that provides sufficient protection to the consumers of this state and results in greater efficiency in bringing new or modified products within the line to market, the approval required by this section may be waived for such period as is deemed appropriate, or until revoked.

23-79-110. Forms - Grounds for disapproval.

The Insurance Commissioner shall disapprove any form filed under § 23-79-109, or withdraw any previous approval, only if the form:

- (1) Is in any respect in violation of or does not comply with this code;
- (2) Contains or incorporates by reference, where the incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract;
- (3) Has any title, heading, or other indication of its provisions which is misleading;
- (4) Is printed or otherwise reproduced in such manner as to render any provision of the form substantially illegible or not easily legible to persons of normal vision;
- (5)(A) Is an individual accident and health contract in which the benefits are unreasonable in relation to the premium charge. Rates on a particular policy form will be deemed approved upon filing with the commissioner if the insurer has filed a loss ratio guarantee with the commissioner and complied with the terms of the loss ratio guarantee. Benefits will continue to be deemed reasonable in relation to the premium so long as the insurer complies with the terms of the loss ratio guarantee. This loss ratio guarantee must be in writing, signed by an officer of the insurer, and must contain at least the following:
 - (i) A recitation of the anticipated target loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved;
 - (ii) A guarantee that the actual Arkansas loss ratios for the experience period in which the new rates take effect, and for each experience period thereafter until new rates are filed, will meet or exceed the loss ratio standards referred to in subdivision (a)(5)(A)(i) of this subsection. If the annual earned premium volume in Arkansas under the particular policy form is less than one million dollars (\$1,000,000) and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nationwide loss ratio for the policy form. If the aggregate earned premium for all states is less than one million dollars (\$1,000,000), the experience period will be extended until the end of the calendar year in which one million dollars (\$1,000,000) of earned premium is attained;
 - (iii) A guarantee that the actual Arkansas, or national, if applicable, loss ratio results for the year at issue will be independently audited at the insurer's expense. This audit must be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the commissioner not later than the date for filing the applicable accident and health policy experience exhibit;
 - (iv) A guarantee that affected Arkansas policyholders will be issued a proportional refund, based on premium earned of the amount necessary to bring the actual aggregate loss ratio up to the loss ratio standards referred to in subdivision (a)(5)(A)(i) of this subsection. If nationwide loss ratios are used, then the total amount refunded in Arkansas will equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned in Arkansas on the policy form and divided by the total

premium earned in all states on the policy form. The refund must be made to all Arkansas policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal ten dollars (\$10.00) or more. The refund will include statutory interest from the end of the experience period until the date of payment. Payment must be made during the third quarter of the year following the experience period for which a refund is determined to be due; and

- (v) A guarantee that refunds of less than ten dollars (\$10.00) will be aggregated by the insurer and paid to the State Insurance Department.
- (B) As used herein, the term "loss ratio" means the ratio of incurred claims to earned premium by number of years of policy duration, for all combined durations.
- (C) As used herein, the term "experience period" means, for any given rate filing for which a loss ratio guarantee is made, the period beginning on the first day of the calendar year during which the rates first take effect and ending on the last day of the calendar year during which the insurer earns one million dollars (\$1,000,000) in premium on the form in question in Arkansas or, if the annual premium earned on the form in Arkansas is less than one million dollars (\$1,000,000) nationally. Successive experience periods shall be similarly determined beginning on the first day following the end of the preceding experience period.
- (D) An insurer whose rates on a policy form are approved pursuant to a loss ratio guarantee shall provide affected policyholders with a notice which advises that rates may be increased more than once a year. For new policyholders with policies subject to the loss ratio guarantee, the notice must be delivered no later than delivery of the policy. Nothing herein shall be deemed to require an insurer to provide the notice required by this subdivision on more than one (1) occasion to any given policyholder while insured under the guaranteed form.

23-79-111. Standard provisions.

- (a) Insurance contracts shall contain such standard or uniform provisions as are required by the applicable provisions of this code pertaining to contracts of particular kinds of insurance. The Insurance Commissioner may waive the required use of a particular provision in a particular insurance policy form if:
 - (1) He finds the provision unnecessary for the protection of the insured and inconsistent with the purposes of the policy; and
 - (2) The policy is otherwise approved by him.
- (b) No policy shall contain any provision inconsistent with or contradictory to any standard or uniform provision used or required to be used, but the commissioner may approve any substitute provision which, in his opinion, is not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.
- (c) In lieu of the provisions required by this code for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the commissioner.

- (d) The provisions of this section shall not apply to policies issued for large commercial risks.

23-79-112. Contents.

- (a) The written instrument in which a contract of insurance is set forth is the policy.
- (b) Every policy shall specify:
 - (1) The names of the parties to the contract;
 - (2) The subject of the insurance;
 - (3) The risks insured against;
 - (4) The time when the insurance thereunder takes effect and the period during which the insurance is to continue;
 - (5) The premium or premium deposit;
 - (6) The policy fee, if any;
 - (7) The minimum premium to be retained, if any, by a property or casualty insurer in the event of cancellation of the policy by the insured; and
 - (8) The conditions pertaining to the insurance.
- (c) If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid shall be included.
- (d) Subsections (b) and (c) of this section shall not apply as to surety contracts or to group insurance policies.
- (e) All life and accident and health policies and annuity contracts issued by domestic insurers, and the forms thereof filed with the commissioner, shall have printed thereon an appropriate designating letter or figure, or combination of letters or figures, or terms identifying the respective forms of policies or contracts, together with the year of adoption of the form. Whenever any change is made in the form, the designating letters, figures, or terms and year of adoption thereon shall be correspondingly changed.
- (f)
 - (1) All individual life, annuity and accident and health policy or contract filings, excluding medicare supplement policies and variable life policies and variable annuities, shall have a notice prominently printed on the first page of the policy or contract stating in substance that the policyholder shall have the right to return the policy or contract within ten (10) days of its delivery, unless the policy or contract provides for a greater period, and to have the premium refunded if after examination of the policy or contract the policyholder is not satisfied for any reason.
 - (2) If the policyholder returns the policy or contract to the insurance company or to the agent through whom it was purchased within ten (10) days of the policy delivery, it shall be void from its inception and the parties shall be in the same position as if no policy or contract had been issued.
- (g) A policy may contain additional provisions not inconsistent with this code and which are:
 - (1) Required to be inserted by the laws of the insurer's domicile;
 - (2) Necessary, on account of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties to the contract;

or

- (3) Desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included therein.
- (h) On and after January 1, 1990, every property and casualty policy shall contain a provision stating the method to be utilized in computing premium refunds in the event of cancellation of the policy by the insured or the insurer.
- (i) The provisions of this section shall not apply to policies issued for large commercial risks.

23-79-113. Charter or bylaw provisions excluded - Exception.

- (a) No policy shall contain any provision purporting to make any portion of the charter, bylaws, or other constituent document of the insurer, other than the subscribers' agreement or power of attorney of a reciprocal insurer, a part of the contract unless the portion is set forth in full in the policy.
- (b) Any policy provision in violation of this section shall be invalid.

23-79-114. Entitlement notwithstanding policy provisions - Health services performed by professionals not licensed under Arkansas Medical Practices Act.

- (a)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases where the policy, contract, plan, or agreement provides for payment or reimbursement for any service provided by persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., the person entitled to benefits or person performing services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is performed by any person licensed under any of the examining boards found in § 17-80-101, as amended by §§ 17-95-301 - 17-95-304.
- (2) Nothing in this subsection shall be construed to amend, alter, or repeal any laws relating to the licensing or use of hospitals.
- (3) The provisions of this subsection shall not apply to any policy, contract, plan, or agreement in effect prior to February 3, 1971.
- (b)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, wherever such policy, contract, plan, or agreement provides for payment or reimbursement for any service in the vision or human eye field provided by persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., the person entitled to benefits or the person performing services under such policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for such service when the service is performed by any person licensed under § 17-90-101 et seq.
- (2) No person entitled to benefits under this subsection shall be denied his or her freedom of choice of any practitioner licensed under § 17-95-201 et seq. or § 17-90-101 et seq. by any insurer or agent or employee of the insurer or by any department, agency, or employee of this state.
- (3) Nothing herein shall be construed to enlarge or diminish the practice of

- optometry as defined by law in § 17-90-101 et seq. and, in accordance with state law, sole and complete authority regarding determination of those acts, services, procedures, and practices which constitute the practice of optometry in this state shall be vested in the State Board of Optometry. This section shall specifically include, but not be limited to, authority of the State Board of Optometry to define the parameters of management and comanagement of persons licensed under § 17-90-101 et seq. in the treatment and management of postoperative and therapeutic care of the human eye.
- (4) The provisions of this subsection shall not apply to any policy, contract, plan, or agreement until persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., become entitled to reimbursement for services by the insurer in the vision or human eye field.
 - (5) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., or the Arkansas Optometry Practices Act, § 17-90-101 et seq., shall be entitled to payment or reimbursement on an equal basis for service in the vision or human eye field.
- (c)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases where the policy, contract, plan, or agreement provides for payment or reimbursement for any services consisting of the diagnosis, medical, mechanical, or surgical treatment of ailments of the human foot provided by persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., the person entitled to benefits or person performing services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is performed by any person licensed under § 17-96-101 et seq.
- (2) No person entitled to benefits under this subsection shall be denied freedom of choice of any practitioner licensed under § 17-95-201 et seq. or § 17-96-101 et seq. by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.
 - (3) Nothing in this subsection shall be construed to enlarge or diminish the practice of podiatry as defined by law in § 17-96-101 et seq.
 - (4) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., or the Arkansas Podiatry Practices Act, § 17-96-101 et seq., shall be entitled to payment or reimbursement on an equal basis for service consisting of the diagnosis, medical, mechanical, and/or surgical treatment of ailments of the human foot.
- (d)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance, or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases where the policy, contract, plan, or agreement provides for payment or reimbursement for any services consisting of psychological evaluation, counseling, psychotherapy, or related mental health services, provided by persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., the person entitled to benefits or persons providing services under the policy, contract, plan, or agreement are entitled to payment or reimbursement on an equal basis for the service when the service is provided by any person licensed as a

psychologist under § 17-97-201 et seq. and operating within his or her area of competence.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice to select any practitioner licensed under § 17-95-201 et seq. or § 17-97-201 et seq. by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of psychology as defined by law in § 17-97-201 et seq.

(4) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., or persons licensed as psychologists under § 17-97-201 et seq., shall be entitled to payment or reimbursement on an equal basis for services consisting of psychological evaluation, counseling, psychotherapy, or related mental health services.

(e)(1) Notwithstanding any provision of any accident and health insurance contract or any group accident and health insurance contract or blanket accident and health insurance contract as provided for in §§ 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, benefits shall not be denied thereunder for any health service performed by any person licensed pursuant to the provisions of the Arkansas Dental Practice Act, § 17-82-101 et seq., if the service performed was within the lawful scope of the person's license and the contract would have provided benefits if the service had been performed by a holder of a license issued pursuant to the provisions of the Arkansas Medical Practices Act, § 17-95-201 et seq.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice to select any practitioner licensed under § 17-95-201 et seq. or § 17-82-101 et seq. by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of dentistry as defined by § 17-82-101 et seq.

(f)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance, or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases where the policy, contract, plan, or agreement provides for payment or reimbursement for any anesthesia services provided by persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., the person entitled to benefits or the persons providing services under the policy, contract, plan, or agreement are entitled to the same method of payment for the service when the service is provided by any person licensed as a certified registered nurse anesthetist and operating within his area of competence.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice to select any practitioner licensed under § 17-87-302 by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of certified registered nurse anesthetists under § 17-87-302.

(4) The purpose of this subsection is to ensure that persons licensed under the

Arkansas Medical Practices Act, § 17-95-201 et seq., or persons licensed as certified registered nurse anesthetists under § 17-87-302 shall be entitled to the same method of payment for anesthesia services.

23-79-115. Entitlement notwithstanding policy provisions - Services performed by outpatient centers.

- (a)(1) Notwithstanding any provisions of any individual or group accident and health insurance policy, or any provision of a policy, contract, plan, or agreement covering hospital or medical services, in cases where the policy, contract, plan, or agreement provides for payment or reimbursement for any health care service provided by hospitals or related facilities as defined in § 20-9-201 or § 20-10-213, the person entitled to payment or reimbursement for services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is provided by facilities licensed as outpatient surgery centers under §§ 20-9-214 and 20-9-215.
- (2) This subsection applies to insurance policies and hospital service corporation contracts which are delivered or issued for delivery in this state more than one hundred twenty (120) days after July 6, 1977, and to such other contracts, plans, or agreements which are entered into or effectuated in this state more than one hundred twenty (120) days after July 6, 1977.
- (b)(1) Notwithstanding any provisions of any individual or group accident and health insurance policy, or any provision of a policy, contract, plan, or agreement covering hospital or medical services, in cases where the policy, contract, plan, or agreement provides for payment or reimbursement for any health care service provided by hospitals or related facilities as defined in § 20-9-201 or § 20-10-213, the person entitled to payment or reimbursement or services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is provided by facilities licensed as outpatient psychiatric centers under §§ 20-9-214 and 20-9-215.
- (2) This subsection applies to insurance policies and hospital service corporation contracts which are delivered or issued for delivery in this state more than one hundred twenty (120) days after July 20, 1979, and to such other contracts, plans, or agreements which are entered into or effectuated in this state more than one hundred twenty (120) days after July 20, 1979.

23-79-116. Execution.

- (a) Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee, or representative authorized by the insurer.
- (b) A facsimile signature of any executing individual may be used in lieu of an original signature.
- (c) No insurance contract which is otherwise valid shall be rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the policy.

23-79-117. Underwriters' and combination policies.

- (a) Two (2) or more authorized insurers may jointly issue and shall be jointly and severally liable on an underwriters' policy bearing their names. Any one (1) insurer may issue policies in the name of an underwriter's department and the policy shall plainly show the true name of the insurer.
- (b) Two (2) or more insurers may, with the approval of the Insurance Commissioner, issue a combination policy which shall contain provisions substantially as follows:
 - (1) That the insurers executing the policy shall be severally liable for the full amount of any loss or damage according to the terms of the policy, or for specified percentages or amounts thereof aggregating the full amount of insurance under the policy; and
 - (2) That service of process or of any notice or proof of loss required by the policy upon any of the insurers executing the policy shall constitute service upon all the insurers.
- (c) This section shall not apply to cosurety obligations.

23-79-118. Noncomplying forms.

Any insurance policy, rider, or endorsement issued and otherwise valid which contains any condition or provision not in compliance with the requirements of this code shall not be thereby rendered invalid but shall be construed and applied in accordance with such conditions and provisions as would have applied had the policy, rider, or endorsement been in full compliance with this code.

23-79-119. Construction of policies.

- (a) Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended, or modified by any rider, endorsement, or application made a part of the policy.
- (b) All insurance contracts which are issued for specific terms and which may be renewed for subsequent terms at the option of the insured or the insurer shall be construed from and after their respective dates of renewal as being new contracts to the extent of having incorporated therein all applicable public policy which by statute or regulation may have become applicable to such contracts in the interval between:
 - (1) Original issuance or last renewal; and
 - (2) The renewal following the newly applicable statement of public policy.
- (c)(1) Except as provided in this subsection, a health insurance issuer that provides individual health insurance coverage for major medical benefits to an individual shall renew or continue in force such coverage at the option of the individual.
- (2) **General Exceptions.** A health insurance issuer may nonrenew or discontinue health insurance coverage providing major medical benefits for an individual in the individual market based only on one (1) or more of the following:
 - (A) **Nonpayment of the Premium.** The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;
 - (B) **Fraud.** The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of

the coverage;

- (C) **Termination of the Plan.** The issuer is ceasing to offer major medical coverage in the individual market in accordance with applicable state or federal law;
 - (D) **Movement Outside the Service Area.** In the case of a health insurance issuer that offers health insurance for major medical coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the issuer is authorized to do business, but only if such individual major medical coverage is terminated under this subdivision (c)(2)(D) uniformly without regard to any health-status related factor of covered individuals; and
 - (E) **Association Membership Ceases.** In the case of health insurance for major medical coverage that is made available in the individual market only through one (1) or more bona fide associations, the membership of the individual in the association, as the basis on which the coverage is provided, ceases but only if such major medical coverage is terminated under this subdivision (c)(2)(E) uniformly without regard to any health status-related factor of covered individuals.
- (3) **Requirements for Uniform Termination of Coverage - Particular Type of Coverage Not Offered.** In the case in which an insurer decides to discontinue offering a particular type of health insurance providing major medical coverage offered to the individual market, coverage of such type may be discontinued by the issuer only if:
- (A) The issuer provides to each covered individual with coverage of this type in such market notice of such discontinuation at least ninety (90) days prior to the date of the discontinuation of such coverage;
 - (B) The issuer offers to each individual in the individual market with coverage of this type the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and
 - (C) In exercising the option to discontinue coverage of this type, and in offering the option of coverage under subdivision (c)(3)(B) of this section, the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.
- (4) **Discontinuance of Such Coverage - In General.** Subject to the provisions of this subsection, in any case in which a health insurance issuer elects to discontinue offering all health insurance providing major medical coverage in the individual market in this state, health insurance coverage may be discontinued by the issuer only if the issuer provides to the Insurance Commissioner and to each individual notice of such discontinuance at least one hundred eighty (180) days prior to the date of expiration of such coverage.
- (5) **Prohibition on Market Reentry.** In the case of a discontinuation in the individual market under this subsection, the issuer may not provide for the issuance of any health insurance providing major medical coverage in the market and state involved during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

- (6) **Exception for Uniform Modification of Coverage.** At the time of coverage renewal, a health insurance issuer may modify the health insurance providing major medical coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.
- (7) **Application to Coverage Offered only Through Associations.** In applying this subsection in the case of health insurance providing major medical coverage that is made available by a health insurance issuer in the individual market only through one (1) or more associations, a reference to an "individual" is deemed to include a reference to such an association of which the individual is a member.
- (8) For purposes of this subsection, the terms or phrases "health insurance issuer", "health insurance coverage" or "coverage", "Insurance Commissioner", "network plan", "health status-related factor", "bona fide association", "individual market", and "eligible individual" shall be defined pursuant to the definitions contained in § 23-86-303.

23-79-120. Binders.

- (a) Binders or other contracts for temporary insurance may be made orally or in writing, and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such applicable endorsements as are designated in the binder, except as superseded by the clear and express terms of the binder.
- (b) No binder shall be valid beyond the issuance of the policy with respect to which it was given, or beyond ninety (90) days from its effective date, whichever period is the shorter.
- (c) If the policy has not been issued, a binder may be extended or renewed beyond the ninety (90) days with the written approval of the Insurance Commissioner or in accordance with such rules and regulations relative thereto as the commissioner may promulgate.
- (d) This section shall not apply to life insurance or accident and health insurance.

23-79-121. Delivery of policy.

- (a) Subject to the insurer's requirements as to payment of premium, every policy shall be mailed or delivered to the insured or to the person entitled to receive it, within a reasonable period of time after its issuance, except where a condition required by the insurer has not been met.
- (b) In the event the original policy is delivered or is required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any property or motor vehicle and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to the property or vehicle is insured, then a duplicate of the policy, or a certificate of insurance setting forth the name and address of the insurer, insurance classification in the case of a vehicle, type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, or memorandum thereof containing the same information, shall be delivered by the agent through whom the insurance was procured to each vendee, mortgagor, or pledgor named in the policy. No insurer shall have any responsibility or liability with respect to compliance or noncompliance with

any requirement of this subsection.

- (c) This subsection does not apply to insurance of aircraft.

23-79-122. Negotiability of premium notes.

- (a) No note given for premiums on insurance in this state shall be negotiated until the policy for which the note was given has been issued and delivered to the maker of the note, and all notes so given shall state the purpose for which the note was given. However, this subsection shall not be applicable in cases where the policy is issued or approved in the form and at the rate applied for and the coverage is effective prior to the issuance or approval.
- (b) Nothing in this section shall be construed in any way to invalidate these notes between the payee and payor, and notes when they become negotiable shall in all respects be as other negotiable paper.

23-79-123. Renewal by certificate.

- (a) Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable may be renewed or extended at the option of the insurer upon a currently authorized policy form and at the premium rate then required for that type of policy, for a specific additional period or periods by certificate or by endorsement of the policy and without requiring the issuance of a new policy.
- (b) By reasonable rules and regulations, or by order, the Insurance Commissioner may deny the use of such certificates for renewal of such types of policies or in such circumstances as may be necessary or advisable to protect insureds who may otherwise hold forms of policies which no longer contain all of the benefits or conditions applicable under similar policies currently issued by the same insurer.
- (c) The provisions of this section shall not apply to policies issued for large commercial risks.

23-79-124. Assignment.

- (a) A policy may be assignable or not assignable, as provided by its terms.
- (b) Subject to its terms relating to assignability, any life or accident and health policy, under the terms of which the beneficiary may be changed upon the sole request of the insured, may be assigned, either by pledge or transfer of title, by an assignment executed by the insured alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer.
- (c) Any assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment until the insurer has received at its home office written notice of termination of the assignment or pledge or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

S.W.2d 831 (1989).

23-79-125. Payment by insurer - Discharge.

- (a) Whenever the proceeds of or payments under a life or accident and health insurance policy or annuity contract become payable in accordance with the terms of the policy

or contract, or the exercise of any right or privilege thereunder, and the insurer makes payment of the amount in accordance with the terms of the policy or contract or in accordance with any written assignment thereof, the person then designated in the policy or contract or by the assignment as being entitled to the benefits shall be entitled to receive the proceeds or payments and to give full acquittance therefor.

- (b) The payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that the other person claims to be entitled to the payment or some interest in the policy or contract.

23-79-126. Forms for proof of loss.

- (a) An insurer shall furnish to any person claiming to have a loss under an insurance contract issued by the insurer forms of proof of loss for completion by the person, within twenty (20) days after a loss has been reported to the insurer, but the insurer shall not, by reason of the requirement to furnish forms, have any responsibility for or with reference to the completion of the proof or the manner of completion or attempted completion.
- (b) However, failure of an insurer to furnish the forms of proof of loss within twenty (20) days after a loss has been reported to the insurer shall constitute a waiver of proof of loss requirements, and the insurer may not thereafter require a proof of loss.
- (c) Further, the provisions of this section shall not be applicable to health, accident, or life insurers.

23-79-127. Claims administration by insurer not waiver.

Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder:

- (1) Acknowledgment of the receipt of notice of loss or claim under the policy;
- (2) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted; or
- (3) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any loss or claim, except that investigating and negotiations may constitute a waiver of proof of loss requirements.

23-79-128. Right to insure spouse's life.

- (a)(1) It shall be lawful for any married woman, by herself and in her name, or in the name of any third person, with his assent as her trustee, to cause to be insured, for her sole use, the life of her spouse for any definite period or for the term of his natural life.
- (2) In case of her surviving her spouse, the sums or net amount of the insurance becoming due and payable by the terms of the insurance shall be payable to her and for her use.
- (3) In case of death of the wife before the decease of her spouse, the amount of the

insurance may be made payable to his or her children for their use, and to their guardian for them, if they are under age, as is provided in the policy of insurance.

- (4) All proceeds and avails of the insurance shall be free from the claims of the representatives of the spouse or of any of his creditors, whether or not the right to change the beneficiary is reserved or permitted. However, subject to the statute of limitations, the amount of any premiums for the insurance paid out of the funds or property of the spouse with intent to defraud creditors, including interest thereon, shall enure to their benefit from the proceeds of the policy, but the company issuing the policy shall be discharged of all liability on the policy by payment of its proceeds in accordance with its terms, unless, before such payment, the company shall have written notice by or in behalf of a creditor of a claim to recover for premiums paid with intent to defraud creditors with specifications of the amount claimed.
- (b) This section shall not be deemed to give the wife any present or vested interest in any policy of life insurance insuring the life of her spouse unless the wife is the owner in fact of the policy, either directly or through her expressly designated trustee, or unless otherwise provided in the policy.
- (c) The provisions of this section shall also govern insurance procured on the life of a wife by her spouse.

23-79-129. Coverage of newborn infants.

- (a)(1) Every accident and health insurance policy, contract, certificate, or health care plan sold, delivered, issued, or offered for sale, issue, or delivery in this state, other than coverage limited to expenses from accidents or specified diseases, whether an individual or group policy, contract, certificate, or plan, which covers the insured and members of the insured's family, shall include coverage for newborn infant children by the insured from the moment of birth.
- (2) The coverage of newborn children shall be the same as is provided for other members of the insured's family and shall include coverage for illness, injury, congenital defects, premature birth, and tests for hypothyroidism, phenylketonuria, and galactosemia, and, in the case of non-Caucasian newborn infants, tests for sickle-cell anemia, as well as any testing of newborn infants hereafter mandated by law, and subject to minimum benefits required by § 23-99-404, shall also include coverage to pay for routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.
- (b) The insurer may require that the insured give notice to his or her insurer of any newborn children within ninety (90) days of the birth or before the next premium due date, whichever is later.
- (c) The Insurance Commissioner shall not approve any policy or contract to be sold, issued, or offered for sale in this state unless it shall specifically include the coverage required in this section for newborn infants.

23-79-130. Group policies - Offer of coverage for impairment of speech or hearing.

- (a) Every insurer which offers for sale, issue, or delivery in this state, any group insurance policy, contract, plan, or agreement for health and accident or medical service or indemnity which covers the insured and members of the insured's family, shall offer coverage for the necessary care and treatment of loss or impairment of speech or hearing, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as other covered services in the policies or contracts.
- (b) The offer of benefits under subsection (a) of this section shall be in writing by offering a rider to the group administrator.
- (c) Nothing in this section shall prohibit the insurance company or not-for-profit health service corporation from including any coverage for loss or impairment of speech, language, or hearing as standard coverage in their policies or contracts.
- (d) The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.
- (e) The additional coverage provided for in this section shall not apply to hearing instruments or devices.

23-79-131. Exemption of proceeds - Life insurance.

- (a)(1) If a policy of insurance is effected by any person on his own life or on another life in favor of a person other than himself or, except in cases of transfer with intent to defraud creditors, if a policy of life insurance is assigned or in any way made payable to the person, the lawful beneficiary or assignee of the policy, other than the insured or the person effecting the insurance or executors or administrators of the insured or the person effecting the insurance, shall be entitled to its proceeds and avails against the creditors and representatives of the insured and those of the person effecting the policy whether or not the right to change the beneficiary is reserved or permitted and whether or not the policy is made payable to the person whose life is insured, if the beneficiary or assignee shall predecease such person.
- (2) However, subject to the statute of limitations, the amount of any premiums for the insurance paid with intent to defraud creditors, including interest thereon, shall enure to their benefit from the proceeds of the policy, but the insurer issuing the policy shall be discharged of all liability thereof by payment of its proceeds in accordance with its terms unless, before the payment, the insurer shall have written notice at its home office, by or in behalf of a creditor, of a claim to recover for transfer made or premiums paid with intent to defraud creditors, with specifications of the amount so claimed.
- (b) For the purposes of subsection (a) of this section, a policy shall also be deemed to be payable to a person other than the insured if, and to the extent that, a facility-of-payment clause or similar clause in the policy permits the insurer to discharge its obligation after the death of the individual insured by paying the death benefits to a person as permitted by the clause.

23-79-132. Exemption of proceeds - Group life.

- (a) A policy of group life insurance or the proceeds thereof payable to the individual

insured or to the beneficiary thereunder shall not be liable, either before or after payment, to be applied by any legal or equitable process to pay any debt or liability of the insured individual, or his beneficiary, or of any other person having a right under the policy. The proceeds of the policy, when not made payable to a named beneficiary or to a third person pursuant to a facility-of-payment clause, shall not constitute a part of the estate of the individual insured for the payment of his debts.

- (b) This section shall not apply to group life insurance issued pursuant to § 23-83-106 to a creditor covering his debtors to the extent that the proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued.

23-79-133. Exemption of proceeds - Accident and health insurance.

The proceeds or avails of all contracts of accident and health insurance and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance or annuity contracts shall be exempt from all liability for any debt of the insured and from any debt of the beneficiary existing at the time the proceeds are made available for his or her use.

23-79-134. Exemption of proceeds - Annuity contracts - Assignability of rights.

- (a) Benefits, rights, privileges, and options under any annuity or variable annuity contract, which are due or prospectively due the annuitant, shall not be subject to execution, attachment, or garnishment, nor shall the annuitant be compelled to exercise the rights, powers, or options under the contract, nor shall creditors be allowed to interfere with or terminate the contract except:
- (1) As to amounts paid for any annuity or variable annuity with intent to defraud creditors, including interest thereon, and of which the creditor has given the insurer written notice at its home office prior to the making of payments to the annuitant out of which the creditor seeks to recover. The notice shall specify the amount claimed, or such facts as will enable the insurer to ascertain the amount, and shall set forth such facts as will enable the insurer to ascertain the insurance or annuity contract, the person insured or annuitant, and the payments sought to be avoided on the ground of fraud; and
 - (2) If the total benefits presently due and payable to any annuitant under all annuity contracts under which he is an annuitant shall at any time exceed the exemptions granted an annuitant by law, a court of appropriate jurisdiction may order the annuitant to pay to a judgment creditor or apply on the judgment, in installments, such portion of the excess benefits as to the court may appear just and proper, after due regard for the reasonable requirements of the judgment debtor and his family, if dependent upon him, as well as any payments required to be made by the annuitant to other creditors under prior court orders.
- (b) If the contract so provides, the benefits, rights, privileges, or options accruing under the contract to a beneficiary or assignee shall not be transferable nor subject to commutation, and, if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained herein for the annuitant shall apply with respect to the beneficiary or assignee.
- (c) An "annuity contract" within the meaning of this section shall be any obligation to

pay certain sums at stated times, during life or lives, or for a specified term or terms, issued for a valuable consideration, regardless of whether or not the sums are payable to one (1) or more persons jointly or otherwise, but does not include payments under life insurance contracts at stated times during life or lives or for a specified term or terms.

- (d) A "variable annuity" contract within the meaning of this section shall be any obligation to pay sums at stated times, during life or lives, or for a specified term or terms, issued for a valuable consideration, regardless of whether or not the sums are payable to one (1) or more persons jointly or otherwise, where the sums payable vary directly according to investment experience with respect to the variable annuity contract, but does not include annuity contracts or payments under life insurance contracts at stated times during life or lives, or for a specified term or terms.

23-79-135. Prompt payment of certain claims required.

In any case where an insured under any hospital, medical, or surgical policy or plan, or any accident policy, becomes entitled to benefits thereunder in an amount of three hundred dollars (\$300) or less and the company, association, or organization, except governmental or nonprofit organizations, issuing the policy or plan denies liability or fails to pay benefits within a reasonable time after demand is made therefor by the insured or member, then the company, association, or organization shall be liable to the insured for the benefits, and, in addition thereto, a penalty in an amount equal to benefits to which the insured is found to be entitled.

23-79-136. Agreement for insurer to invest premium prohibited.

- (a) It is unlawful for any insurance company authorized to do business in this state to issue or offer for sale or issue in this state any policy of insurance under which the insurer agrees to invest a portion of the policy premium, whether for one (1) or more years, and hold a portion of the policy premium for investment in its own name either directly or indirectly, or as trustee for the benefit of the insured or for the benefit of a certain class of policyholders.
- (b) Any insurance company issuing or offering to issue any policy in violation of the provisions of subsection (a) of this section shall be fined in any sum not less than five hundred dollars (\$500) nor more than five thousand dollars (\$5,000), and in addition, the authority of the insurance company to do business in this state may be revoked.
- (c)(1) This section shall not be construed to prohibit the offer or sale of a variable annuity contract issued, or variable benefit payable, in compliance with the applicable requirements of the Arkansas Insurance Code, § 23-60-101 et seq., the Securities Act of 1933, the Investment Company Act of 1940, and the Arkansas Securities Act, § 23-42-101 et seq.
- (2) This section shall not apply to contracts with respect to amounts maintained by insurers in such group pension, profit-sharing, and annuity separate accounts as may be authorized by law.
- (3) This section shall not apply to policy provisions permitting benefits to be left on deposit with the insurer at a specified rate of interest.

23-79-137. Coverage for adopted minors.

- (a) Every accident and health insurance policy, self-insured health plan, hospital and medical service contract, contract, certificate, or health care plan sold, delivered, issued, or offered for sale, issue, or delivery in this state, whether an individual or group policy, contract, or plan, which covers the insured and members of the insured's family, shall include coverage for any minor under the charge, care, and control of the insured whom the insured has filed a petition to adopt. The coverage of the minor shall be the same as provided for other members of the insured's family.
- (b) The coverage required by this section shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage required by this section shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor.
- (c) The coverage required by this section shall terminate upon the dismissal or denial of a petition for adoption.

23-79-138. Information to accompany policies.

- (a) Every policy of life insurance, accident and health insurance, property insurance, or casualty insurance issued after January 1, 1988, and covering risks located, resident, or to be performed in the State of Arkansas shall be accompanied by the following information:
 - (1) The complete address and telephone number, 800 number if possible, of the policyholder's service office of the company issuing the policy;
 - (2) The name, address, and telephone number of the agent soliciting the policy, if applicable; and
 - (3) The address and telephone number, 800 number if available, of the State Insurance Department.
- (b) Any person who fails to comply with the provisions of this section shall be subject to the penalties provided in § 23-60-108.
- (c) The Insurance Commissioner is authorized to adopt appropriate rules and regulations to enforce and carry out the intent and purposes of this section.

23-79-139. Benefits for alcohol or drug dependency treatment.

- (a)(1) Every insurer, hospital and medical service corporation, and health maintenance organization transacting accident and health insurance in this state shall offer and make available under all group policies, contracts, and plans providing hospital and medical coverage on an expense incurred, service, or prepaid basis benefits for the necessary care and treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors, except as provided in this section.
 - (2)(A) The offer for these benefits shall be subject to the right of the policy or contract holder to reject the coverage or select any alternative level of benefits.
 - (B) The rejection by the policy or contract holder shall be in writing.
- (b) Any benefits provided under alcohol or drug dependency coverage shall be determined as necessary care and treatment in an alcohol or drug dependency treatment facility or care and treatment in a hospital.

- (c) Treatment may include detoxification, administration of a therapeutic regimen for the treatment of alcohol or drug dependent or substance abusing persons, and related services.
- (d) The facility or unit may be:
 - (1) A unit within a general hospital or an attached or freestanding unit of a general hospital;
 - (2) A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital; or
 - (3) A freestanding facility specializing in treatment of persons who are substance abusers or are alcohol or drug dependent, and may be identified as "chemical dependency, substance abuse, alcoholism, or drug abuse facilities", "social setting detoxification facilities", and "medical detoxification facilities", or by other names if the purpose is to provide treatment of alcohol or drug dependent or substance abusing persons, but shall not include halfway houses or recovery farms.
- (e) Every policy or contract of insurance that provides benefits for alcohol or drug dependency treatment and that provides total annual benefits for all illnesses in excess of six thousand dollars (\$6,000) is subject to the following conditions:
 - (1) The policy or contract shall provide, for each twenty-four-month period, a minimum benefit of six thousand dollars (\$6,000) for the necessary care and treatment of alcohol or drug dependency;
 - (2) No more than one-half ($1/2$) of the policy's or contract's maximum benefits for alcohol or drug dependency for a twenty-four-month period shall be paid for the necessary care and treatment of alcohol or drug dependency in any thirty-consecutive-day period; and
 - (3) The policy or contract shall provide a minimum benefit of twelve thousand dollars (\$12,000) for the necessary care and treatment of alcohol or drug dependency for the life of the recipient of benefits.
- (f) For the purposes of this section, the term "alcohol or drug dependency treatment facility" shall mean a public or private facility, or unit in a facility, which is engaged in providing treatment twenty-four (24) hours a day for alcohol or drug dependency or substance abuse, which provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a physician, and which is also properly licensed or accredited to provide those services by the Bureau of Alcohol and Drug Abuse Prevention of the Department of Health.
- (g) Nothing in this section shall prohibit any certificate or contract from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for alcohol or drug dependency.
- (h) As used in this section, unless the context otherwise requires, "alcohol or drug dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.
- (i) This section shall apply to group policies or contracts delivered or issued for delivery or renewed in this state after November 17, 1987, but shall not apply to blanket short-

term travel accident only, limited or specified disease, conversion policies or contracts, nor to policies or contracts referred to as medicare supplement policies, designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act.

23-79-140. Mammograms.

- (a)(1) "Mammography" means radiography of the breast.
- (2) "Screening mammography" is a radiologic procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two (2) views of each breast and includes a physician's interpretation of the results of the procedure.
- (3) "Diagnostic mammography" is a problem-solving radiologic procedure of higher intensity than screening mammography provided to women who are suspected to have breast pathology. Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately reviewed by the physician interpreting the study, and additional views are obtained as needed. A physical examination of the breast by the interpreting physician to correlate the radiologic findings is often performed as part of the study.
- (b) Every accident and health insurance company, hospital service corporation, health maintenance organization, or other accident and health insurance provider in the State of Arkansas shall offer, after January 1, 1990, to each master group contract holder as an optional benefit, coverage for at least the following mammogram screening of occult breast cancer:
 - (1) A baseline mammogram for a woman covered by such policy who is thirty-five (35) to forty (40) years of age;
 - (2) A mammogram for a woman covered by such policy who is forty (40) to forty-nine (49) years of age, inclusive every one (1) to two (2) years based on the recommendation of such woman's physician;
 - (3) A mammogram each year for a woman covered by such policy who is at least fifty (50) years of age;
 - (4) Upon recommendation of a woman's physician, without regard to age, where such woman has had a prior history of breast cancer or where such woman's mother or sister has had a history of breast cancer; and
 - (5) Insurance coverage for screening mammograms will not prejudice coverage for diagnostic mammograms as recommended by the woman's physician.
- (c)(1) The insurers shall pay not less than fifty dollars (\$50.00) for each screening mammogram, which shall include payment for both the professional and technical components.
- (2) In case of hospital out-patient screening mammography, and comparable situations, where there is a claim for professional services separate from the claim for technical services, the claim for professional component will not be less than forty percent (40%) of the total fee.
- (d) Furthermore, no insurer shall pay for mammographies performed in an unaccredited facility after January 1, 1990.

23-79-141. Children's Preventive Health Care Act.

- (a) **Title.** This section shall be known and may be cited as the "Children's Preventive Health Care Act".
- (b) **Declaration of Purposes.** The purpose of this section is to assure that all children eighteen (18) years of age and younger are provided with insurance coverage for preventive health care services during their formative years in order to facilitate early detection and prevention of physical and mental illness, thereby avoiding the risks of the extreme costs associated with many preventable childhood diseases. In addition to improving the health of children, providing insurance coverage for children's preventive health care services enhances the care-giving skills of parents and helps strengthen the family unit. Providing insurance coverage for children's preventive health care will also reduce the disruption to the emotional and financial well-being of families that often accompanies physical and mental illness among children.
- (c) **Definitions.** As used in this section:
 - (1) "Children's preventive health care services" means physician-delivered or physician-supervised services for eligible dependents from birth through age eighteen (18), with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section; and
 - (2) "Periodic preventive care visits" 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.
- (d) **Applicability.**
 - (1) Every accident and health insurer, hospital or medical service corporation, health maintenance organization, fraternal benefit society, and self-insured plan transacting accident and health insurance or providing accident and health coverage in this state which delivers, issues for delivery in this state, or renews, extends, or modifies accident and health policies, contracts, certificates, and plans providing hospital and medical coverage on an expense-incurred, service, or prepaid basis, which contracts provide coverage for a family member of the insured person, shall provide to the contract holder coverage for periodic preventive care visits for covered persons from the moment of birth through the age of eighteen (18).
 - (2) This section does not apply to disability income, specified disease, medicare supplement, hospital indemnity, or accident-only policies.
- (e) **Coverage.**
 - (1) Each accident and health insurance policy, contract, certificate, or plan providing benefits for children's preventive health care services on a periodic basis shall include twenty (20) visits at approximately the following age intervals: birth, two (2) weeks, 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, six (6) years, eight (8) years, ten (10) years, twelve (12) years, fourteen (14) years, sixteen (16) years, and eighteen (18) years.

- (2) An accident and health insurance policy, contract, certificate, or plan may provide that children's preventive health care services which are rendered during a periodic review shall only be covered to the extent that those services are provided by or under the supervision of a single physician during the course of one (1) visit.

(f) Reimbursement, Coinsurance, and Deductibles.

- (1) The benefits which are mandated by this section shall be reimbursed at levels established by the Insurance Commissioner which shall not exceed those established for the same services under the Medicaid program in the State of Arkansas.
- (2)(A) Benefits for recommended immunization services shall be exempt from any copayment, coinsurance, deductible, or dollar limit provisions in the accident and health insurance policy. This exemption shall be explicitly stated in the policy.
- (B) All other children's preventive health care services will be subject to copayment, coinsurance, deductible, or dollar limit provisions in the accident and health insurance policy.

23-79-142. Payment for services of psychological examiners.

Every insurer or hospital and medical service corporation which issues a group accident and health insurance policy, contract, or agreement in this state which provides for mental health coverage shall offer coverage for the payment of services rendered by psychological examiners. The offer shall be made either at the time of application for, or upon the first renewal of such policy, contract, or agreement after July 15, 1991. If such an offer is accepted, the amount paid for services provided by psychological examiners shall be subject to the same limitations as set forth in the policy for mental health coverage.

23-79-143. [Repealed.]

23-79-144. Minor children - Certain provisions denying or restricting coverage void.

- (a) No contract of individual or group health care coverage sold, delivered, issued for delivery, renewed, or offered for sale in this state by any insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement, or hospital or medical services corporation shall, directly or indirectly, restrict or deny health care coverage due to the fact that the minor child does not reside with the noncustodial parent or that the parent-child relationship was established through a paternity action or that the minor child is covered through the state-administered medicaid program or that the minor child is not claimed as a dependent on the noncustodial parent's federal or state income tax return. Furthermore, no insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement, or hospital or medical services corporation shall, directly or indirectly, restrict or deny benefits to a minor child because the child lives outside of its service area; benefits provided outside the service area shall be in accordance with the terms and conditions of the health care plan. All contract of individual or group health care coverage sold, delivered, issued for delivery, renewed, or offered for sale in this state

by any insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement, or hospital or medical services corporation shall provide for the immediate enrollment of the minor child or children.

- (b) Any insurance policy provision which would deny or restrict coverage to a minor child under such circumstances shall be void as against public policy.

23-79-145. [Repealed.]

This section, concerning basic health care insurance for children, was repealed by Acts 1995, No. 685, § 2. The section was derived from Acts 1993, No. 1158, §§ 1-7. For present law, see § 23-79-141.

23-79-146. Subrogation recovery.

- (a)(1) Any casualty insurer, accident and health insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement, or hospital or medical services corporation that issues, delivers, or renews a contract of accident and health insurance or individual or group accident and health care coverage containing a provision for subrogation for any benefits or services of any kind furnished to an insured, or for payments made or credit extended to or on behalf of any covered person for a physical condition or injury caused by a third party or for which a third party may be liable, shall be entitled to receive subrogation benefits from such third party.
- (2) In the event that an insured or covered person recovers from a third party, reasonable cost of collection and attorney's fees thereof shall be assessed against the insurer and the insured in the proportion each benefits from the recovery.
- (b) In the event more than one (1) casualty insurer, accident and health insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement, or hospital or medical services corporation having contractual subrogation rights is entitled to the subrogation benefits specified in subsection (a) of this section, reasonable cost of collection and attorney's fees thereof shall be assessed against the insurers and the insured in the proportion each benefits from the recovery.

23-79-147. Prescription medication.

- (a) As used in this section:
- (1) "Commissioner" means the Insurance Commissioner of the State Insurance Department;
- (2) "Insurance policy" means any individual, group, or blanket policy, contract, or evidence of coverage written, issued, amended, delivered, or renewed in this state, or which provides such insurance for residents of this state by an insurance company, hospital medical corporation, or health maintenance organization; and
- (3) "Medical literature" means articles from major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 107 Stat. 591 (1993), 42 U.S.C. § 1395x(t)(2)(B), as amended.
- (b) No insurance policy that provides coverage for prescription drugs shall limit or exclude coverage for any drug approved by the United States Food and Drug

Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided:

- (1) The drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one (1) or more such compendia:
 - (A) The American Hospital Formulary Service drug information;
 - (B) The United States Pharmacopoeia dispensing information;
 - (2) The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.
- (c) Coverage of a drug required by subsection (b) of this section includes medically necessary services associated with the administration of the drug, provided such services are covered by the insurance policy.
- (d) Subsection (b) of this section shall not be construed to do any of the following:
- (1) Require coverage for any drug if the United States Food and Drug Administration has determined its use to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed;
 - (2) Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States Food and Drug Administration; or
 - (3) Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

23-79-148. Medical transportation services.

- (a)(1) Every insurance policy, other than a policy excluded pursuant to subsection (d) of this section, which provides specific coverage exclusively for medical transportation services, that is sold, delivered, issued for delivery, renewed, or offered for sale in this state by an insurer shall contain a provision providing for direct reimbursement to the provider of covered medical transportation service, if the provider has not received payment for those services from any other source.
- (2) The service fee charged shall be in accordance with the American Ambulance Association practice guidelines and shall not be more than the normal charge for the services.
- (b) This section shall not apply if the provider for the medical transportation services has entered into a contract for direct payment with the insurer.
- (c)(1) For the purpose of this section, "direct reimbursement" means the insurer shall pay the medical transportation service directly, pursuant to a claim filed by the insured, and the medical transportation provider shall not demand payment from the insured until having received payment from the insurer.
- (2) Upon receiving payment from the insurer, the medical transportation provider may demand payment from the insured for any unpaid portion of the provider's fee.
- (d) This section shall not apply to any accident and health care policy, whether the policy

is in the form of a health maintenance organization evidence of coverage or health care plan as defined in § 23-76-102(4) and (5), or an accident and health policy governed by §§ 23-85-101 - 23-85-134, 23-85-136, and 23-85-137, or a group and blanket accident and health insurance policy governed by §§ 23-86-101 - 23-86-118, or a medicare supplement policy, or any other form.

23-79-149. Prescription drug benefits.

- (a) As used in this section, "insurance policy" means any individual, group, or blanket policy, contract, or evidence of coverage written, issued, amended, delivered, or renewed in this state, or which provides such insurance for residents of this state, by an insurance company, hospital medical corporation, or health maintenance organization.
- (b) No insurance company, hospital medical corporation, or health maintenance organization issuing insurance policies in this state shall contract with a pharmacist, pharmacy, pharmacy distributor, or wholesale drug distributor, nonresident or otherwise, to provide benefits under such insurance policies for the shipment or delivery of a dispensed legend drug into the State of Arkansas, unless the pharmacist, pharmacy, or distributor has been granted a license or permit from the Arkansas State Board of Pharmacy to operate in the State of Arkansas.
- (c)(1) Each insurance policy shall apply the same coinsurance, co-payment, and deductible factors to covered drug prescriptions filled by a pharmacy provider who participates in the insurance policy's network if the provider meets the contract's explicit product cost determination.
 - (2) Nothing in this subsection shall be construed to prohibit the insurance policy from applying different coinsurance, copayment, and deductible factors between and among generic and brand name drugs.
- (d) Insurance policies shall not set a limit on the quantity of drugs which an enrollee may obtain at any one (1) time with a prescription, unless the limit is applied uniformly to all pharmacy providers in the insurance policy's network.
- (e)(1) For the purpose of this subsection, "maintenance drug" means a drug prescribed by a practitioner who is licensed to prescribe drugs and used to treat a medical condition for a period greater than thirty (30) days.
 - (2) Insurance policies shall not insist or mandate any provider to change an enrollee's maintenance drug, unless the prescribing provider and enrollee agree to such change.
 - (3) Notwithstanding other provisions of law to the contrary, insurance policies that change an enrollee's maintenance drug without the consent of the provider and enrollee shall be liable to the provider or enrollee or both for any damages resulting from the change.
- (f) The Insurance Commissioner shall enforce the provisions of this section and shall impose and collect a penalty of one thousand dollars (\$1,000) for the first violation of this section and a penalty of five thousand dollars (\$5,000) for each subsequent violation of this section. In addition, the commissioner shall have all the powers to enforce this section as are granted to the commissioner elsewhere in the Arkansas Insurance Code, § 23-60-101 et seq.

- (g) The commissioner shall have all the powers to enforce this section, including, but not limited to, ensuring that the different coinsurance, copayment, and deductible factors applicable between and among generic and brand name drugs are reasonable, as are granted to the commissioner elsewhere in the Arkansas Insurance Code, § 23-60-101 et seq.

23-79-150. Health care plan - Health carrier.

- (a)(1)(A) "Health care plan" means any individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a carrier in this state, including indemnity and managed care plans.
- (B) "Health care plan" does not mean a plan that provides coverage only for:
- (i) A specified accident or accident-only coverage or long-term care insurance as defined in the Long-Term Care Insurance Act, § 23-97-201 et seq.
 - (ii) A Medicare supplement policy of insurance, as defined by the Insurance Commissioner by regulation;
 - (iii) Coverage under a plan through Medicare, Medicaid, or the Federal Employees Health Benefit Program;
 - (iv) Any coverage issued under Chapter 55 of Title 10 of the U.S. Code, existing on January 1, 2001, and any coverage issued as supplemental to that coverage; and
 - (v) Any coverage issued as supplemental to liability insurance, workers' compensation, or similar insurance; and
- (2) "Health carrier" means any accident and health insurance company, referred to in law as disability insurance company, hospital or medical services corporation, or health maintenance organization, including a so-called dental maintenance organization, issuing or delivering health care plans in this state.
- (b)(1) Every health carrier shall offer optional coverage in its health care plans for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures.
- (2) This coverage shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. (3) This coverage shall be the same as that provided for any other musculoskeletal disorder in the body and shall be provided whether prescribed or administered by a physician or dentist.
- (c)(1) The policyholder shall accept or reject the optional coverage in writing on the application.
- (2) The application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.
- (d) Nothing in this section shall prevent an insurer from including such coverage for any or all musculoskeletal disorders affecting any bone or joint in the face, neck, or head as part of a policy's basic coverage, in lieu of offering optional coverage.

- (e) This section shall apply to those health care plans issued, delivered, renewed, extended, amended, or modified on or after August 13, 2001.

Subchapter 2. Suits Against Insurers.

23-79-201. Claims arising outside the United States - Automobile liability insurer.

A person having a claim for personal injury or property damage arising out of the use of a motor vehicle in a foreign country by another who, at the time of the injury or damage, was covered by a policy of automobile liability insurance with an insurer subject to the jurisdiction of the courts of this state, may sue the insurer directly on the claim in any court of competent jurisdiction in the county of which the person was a resident at the time the injury or damage occurred.

23-79-202. Limitation of actions.

- (a) An action may be maintained in the courts of this state by an insured or any other person on his behalf to recover on any claim or loss arising under a policy of insurance on property or life against the insurer issuing the policy or against the sureties on any bond filed by the insurer as a condition precedent to its right to do business in this state, at any time within the period prescribed by law for bringing actions on promises in writing.
- (b) Any stipulation or provision in the policy or contract requiring the action to be brought within any shorter time or be barred is void.

23-79-203. Trial by jury.

- (a) No insurance policy or annuity contract shall contain any condition, provision, or agreement which directly or indirectly deprives the insured or beneficiary of the right to trial by jury on any question of fact arising under the policy or contract.
- (b) All such provisions, conditions, or agreements shall be void.

23-79-204. Venue.

- (a) An action brought in this state by or in behalf of the insured or beneficiary against an insurer as to a loss occurring or benefits or rights provided under an insurance policy or annuity contract shall be brought in either:
 - (1) The county in which the loss occurred, or the insured died, in the case of life insurance; or
 - (2) The county of the insured's residence at the time of the loss or death.
- (b) Actions brought in this state against an insurer under § 23-79-210, which provides that the liability insurer may be sued directly where the insured is legally immune, shall be brought either in the county where the injury or damage occurred or where one (1) or more of the plaintiffs resided at the time of the injury or damage.
- (c) The venue of all other actions against a domestic insurer shall be as provided in § 16-

60-104.

23-79-205. Service of process.

- (a) In any suit brought in this state against an insurer, process may be served upon the insurer as follows:
 - (1) As to domestic insurers, service of process may be had only in the manner as provided by § 16-58-124;
 - (2) As to licensed foreign or alien insurers, service on and after January 1, 2003, may be made as provided in § 23-63-301 et seq.;
 - (3) As to suits against unauthorized insurers, service of process shall be made as provided in §§ 23-65-101 - 23-65-104, 23-65-201 - 23-65-205, and 23-65-301 - 23-65-318 for unauthorized insurers and surplus lines.
- (b) Any service of process shall be returnable to the court having jurisdiction under § 23-79-204.

23-79-206. Evidence of death of person in military service.

- (a) It shall be competent and proper in the trial of causes arising from death claims against insurers, accruing on account of death of the insured in foreign lands and while in the service of the United States government as a member of the armed forces of the United States, to introduce as evidence a certificate from the appropriate officer of the armed services having the authority to make the certificate, certifying the death of the insured.
- (b) When the certificate, officially signed and certified as provided in subsection (a) of this section, has been introduced in evidence in the trial, it shall be received and considered in the trial as prima facie evidence of the death of the insured.

23-79-207. Substantial compliance - Fire insurance upon personal property.

In all actions against any insurer for any claim accruing, or arising upon, or growing out of any fire insurance policy upon personal property issued by the insurer, proof of a substantial compliance with the terms, conditions, and warranties of the policy upon the part of the insured or his assigns shall be deemed sufficient and entitle the plaintiff to recover in the action.

23-79-208. Damages and attorney's fees on loss claims.

- (a)(1) In all cases where loss occurs and the cargo, property, marine, casualty, fidelity, surety, cyclone, tornado, life, accident and health, medical, hospital, or surgical benefit insurance company and fraternal benefit society or farmers' mutual aid association or company liable therefor shall fail to pay the losses within the time specified in the policy after demand is made, the person, firm, corporation, or association shall be liable to pay the holder of the policy or his or her assigns, in addition to the amount of the loss, twelve percent (12%) damages upon the amount of the loss, together with all reasonable attorney's fees for the prosecution and collection of the loss.
- (2) In no event will the holder of the policy or his or her assigns be liable for the

attorney's fees incurred by the insurance company, fraternal benefit society, or farmers' mutual aid association in the defense of a case where the insurer is found not liable for the loss.

- (b) When attorney's fees are due a policyholder or his or her assigns, they shall be taxed by the court where the same is heard on original action, by appeal or otherwise, and shall be taxed up as a part of the costs therein and collected as other costs are or may be by law collected.
- (c) Writs of attachment or garnishment filed or issued after proof of loss or death has been received by the company shall not defeat the provisions of this section, provided the company or association desiring to pay the amount of the claim as shown in the proof of loss or death may pay the amount into the registry of the court, after issuance of writs of attachment and garnishment in which event there shall be no further liability on the part of the company.
- (d) Recovery of less than the amount demanded by the person entitled to recover under the policy shall not defeat the right to the twelve percent (12%) damages and attorney's fees provided for in this section if the amount recovered for the loss is within twenty percent (20%) of the amount demanded or which is sought in the suit.
- (e)(1) Notwithstanding the foregoing provisions of subsections (a)-(d) of this section, this section is not intended to either vitiate or supplant the provisions of the Arkansas Rules of Civil Procedure, which rules and the relief described therein remain available to any litigant under the circumstances described in this section.
(2) Nothing in this section is intended to supersede, supplant, or in any way affect the rights and remedies under applicable law currently available to the insurance company, fraternal benefit society, or farmers' mutual aid association or company against policyholders who file fraudulent claims.

23-79-209. Allowance of attorney's fees in suits to terminate, modify, or reinstate policy.

- (a) In all suits in which the judgment or decree of a court is against a life, property, accident and health, or liability insurance company, either in a suit by it to cancel or lapse a policy or to change or alter the terms or conditions thereof in any way that may have the effect of depriving the holder of the policy of any of his or her rights thereunder, or in a suit for a declaratory judgment under the policy, or in a suit by the holder of the policy to require the company to reinstate the policy, the company shall also be liable to pay the holder of the policy all reasonable attorney's fees for the defense or prosecution of the suit, as the case may be.
- (b) The fees shall be based on the face amount of the policy involved.
- (c) The attorney's fees shall be taxed by the court where the suit is heard on original action, by appeal or otherwise, and shall be taxed up as a part of the costs therein and collected as other costs are or may be by law collected.

23-79-210. Direct cause of action against liability insurer where insured not subject to tort suit.

- (a)(1) When liability insurance is carried by any cooperative nonprofit corporation, association, or organization, or by any municipality, agency, or subdivision of a

municipality, or of the state, or by any improvement district or school district, or by any other organization or association of any kind or character and not subject to suit for tort, and if any person, firm, or corporation suffers injury or damage to person or property on account of the negligence or wrongful conduct of the organization, association, municipality, or subdivision, its servants, agents, or employees acting within the scope of their employment or agency, then the person, firm, or corporation so injured or damaged shall have a direct cause of action against the insurer with which the liability insurance is carried to the extent of the amounts provided for in the insurance policy as would ordinarily be paid under the terms of the policy.

- (2) The insurer shall be directly liable to the injured person, firm, or corporation for damages to the extent of the coverage in the liability insurance policy, and the plaintiff may proceed directly against the insurer regardless of the fact that the actual tortfeasor may not be sued under the laws of the state.
- (b) Any of the organizations or entities not subject to suit for tort described in subsection (a) of this section and the officers of those organizations or entities upon the request of any person so injured or damaged shall disclose the existence of any liability insurance, the name of the insurer, and the terms, amounts, and limits provided by the policy or policies.
- (c)(1) Nothing in this section shall be deemed to require the organization or entity not subject to suit for tort to carry liability insurance. This section provides only for a direct action against the insurer by the injured or damaged person in the event liability insurance is so carried.
- (2) The substance of this section shall by operation of law be a part of any liability insurance policy so carried, notwithstanding the terms of the policy itself; and any limitation in any policy restricting the right to recover to a judgment first being obtained against a tortfeasor shall be void.

Subchapter 3.

Minimum Standards - Commercial Property and Casualty Insurance Policies.

23-79-301. Purpose.

The purpose of this subchapter is to provide minimum standards for commercial lines property and casualty insurance policies or contracts. These minimum standards are designed to minimize restrictions in coverage and to assure minimum standards for these commercial policies or contracts for the protection of the public. This subchapter is not intended to impede flexibility and innovation in the development of commercial property and casualty insurance policy or contract form or content. This subchapter is not intended to conflict with the provisions concerning insurance contracts in the Arkansas Insurance Code, § 23-60-101 et seq., and, in particular, the provisions of § 23-60-105. This subchapter is not intended to conflict with nor apply to insurance policies and contracts of surplus line insurers operating in this state in compliance with § 23-65-310.

23-79-302. Definition.

For purposes of this subchapter, a claims-made policy as referenced in § 23-79-306,

means a policy which provides coverage if a claim for damages is first made during the policy period.

23-79-303. Applicability - Exceptions.

This subchapter shall apply to property and casualty insurance on commercial risks in this state, except:

- (1) Reinsurance;
- (2) Insurance against loss of or damage to aircraft, their hulls, accessories, and equipment or against liability arising out of the ownership, maintenance, or use of aircraft;
- (3) Ocean marine or foreign trade insurance;
- (4) Medical malpractice insurance;
- (5) Title insurance;
- (6) Surety or fidelity insurance;
- (7) Credit insurance;
- (8) Workers' compensation or employers' liability insurance; or
- (9) Large commercial risks.

23-79-304. Construction.

This subchapter shall be deemed cumulative of prior laws. No prior law or part of a law shall be deemed to be in conflict with this subchapter unless failure to so determine would prevent giving effect to an explicit provision of this subchapter.

23-79-305. Violations - Order.

- (a) Whenever the Insurance Commissioner shall have reason to believe that any person has violated any provision of this subchapter, he shall issue and serve upon the person a statement of the alleged violations and a notice of hearing as provided by § 23-79-309.
- (b) If, after a hearing, the commissioner determines that the person has violated a provision of this subchapter, he shall issue a written order which, in his discretion, may do one (1) or more of the following:
 - (1) Revoke the certificate of authority of the insurer or the license of the rate service organization;
 - (2) Suspend the certificate of authority of the insurer or the license of the rate service organization; and
 - (3) Require the payment of a monetary penalty of not more than one thousand dollars (\$1,000) for each violation or, if the commissioner has found willful violations, a penalty of not more than ten thousand dollars (\$10,000) for each violation.

23-79-306. Requirements.

The following requirements are applicable only as to claims-made policies as defined in § 23-79-302:

- (1) The policy application and the initial page of each claims-made policy must

- include a conspicuous notice at the top indicating that the contract is a claims-made policy;
- (2) The insurer must provide at no additional charge an automatic sixty-day extended reporting period upon cancellation or termination of the policy by either the insured or insurer;
 - (3) At the expiration of the automatic sixty-day extended reporting period as required by subdivision (2) of this section, the insurer must offer an extended reporting period endorsement. Any notice of termination of a claims-made policy must include a disclosure advising the insured and his agent of the availability of and premium for an extended reporting period endorsement and the importance of purchasing the coverage;
 - (4) The premium for any extended reporting period endorsement shall be based upon the rates and rating rules in effect at the inception date of the last policy period of the claims-made policy;
 - (5) Form or rate/rule filings restricting the risks to be covered by an extended reporting period endorsement shall not be approved or accepted for use by the Insurance Commissioner;
 - (6) The limit of liability in the policy aggregate for the optional extended reporting period endorsement offered by the insurer shall be no less than the greater of the amount of coverage remaining in the expiring policy aggregate or fifty percent (50%) of the aggregate at policy inception. The insurer may offer to increase the original amount of the aggregate limit of liability applicable during the period of the extended reporting period endorsement;
 - (7)(A) A retroactive date may only be advanced with the written consent of the first named insured and upon one (1) or more of the following conditions:
 - (i) If there is a change in insurer other than another insurer within the same insurance holding company or group;
 - (ii) If there is a substantial change in the insured's operations which would have been a material factor in the insurer's acceptance or declination of the risk; or
 - (iii) At the request of the first named insured.
 - (B) Prior to advancement of the retroactive date under subdivisions (7)(A)(i)-(iii) of this section, the insured must receive a disclosure form for his signature which acknowledges that he has been advised of his right to purchase an extended reporting period endorsement; and
 - (8) The insurer must provide the following loss information to the named insured within thirty (30) days of the insured's request and within fifteen (15) days after notice of cancellation or nonrenewal is issued:
 - (A) Description of closed claims including the date and description of occurrence, amount of payments, if any;
 - (B) Description of open claims including the date and description of occurrence, amount of payment, if any, and an estimate of reserves, if any; and
 - (C) Information on notices of occurrence including the date and an estimate of reserves, if any.

23-79-307. Standards.

In addition to other applicable provisions of the Arkansas Insurance Code, § 23-60-101 et seq., insurers and insurance policies subject to the provisions of this subchapter shall meet the following standards:

- (1) Notice of claim given by or on behalf of the named insured to any authorized agent of the insurer with specific information to identify the insured is deemed notice of claim to the insurer;
- (2) Policies may be issued for a term in excess of twelve (12) months with the premium adjustable on an annual basis if the policy contains an express provision to that effect. At least thirty (30) days' advance notice in writing of the premium to be charged on the policy anniversary date must be given to the insured and the agent of record if the insured has furnished the information necessary to calculate the premium;
- (3) Forms or endorsements issued after the policy inception date not at the request of the named insured which reduce, restrict, or modify the original policy coverage must be accepted and signed by the named insured;
- (4) Any policy providing an aggregate limit of liability within the schedule of limits must include a notice specifying that the policy limit is an "aggregate". The aggregate limit provision must be clearly defined within the policy;
- (5)(A) Policies containing provisions which would reduce the limit of liability available for judgments or settlements by the amount of payment made for defense cost or claim expenses shall not be approved by the Insurance Commissioner unless a separate limit for defense costs equal to one hundred percent (100%) of the annual aggregate limit of liability stated in the policy for judgments or settlements is offered for defense costs or claims expenses to the insured. However, no policy covering automobile liability insurance may contain the defense within the limits concept.
(B) This subsection shall not apply to policies or contracts which the commissioner may exempt by order upon a finding that this subsection may not practically be applied or that its application is not necessary or desirable for the protection of the public; and
- (6)(A) When an insurer revises its rates or rules and the revision results in a premium increase equal to or greater than twenty-five percent (25%) on any renewal policy issued for a term of twelve (12) months or less, the insurer shall mail or deliver to the insured's agent not less than thirty (30) days prior to the effective date of renewal, and to the insured not less than ten (10) days prior to the effective date of renewal, notice specifically stating the insurer's intention to increase the premium by an amount equal to or greater than twenty-five percent (25%).
(B) If the notice is not given as stated in subdivision (6)(A) of this section, the insurer is required to extend the existing policy thirty (30) days from the date such notice is mailed or delivered. The premium for the policy as extended in such circumstances shall be no more than the pro rata premium of the existing policy.
- (7) Except in the case of nonpayment of premium, an insurer shall renew a policy, unless a written notice of nonrenewal is mailed at least sixty (60) days prior to the

expiration date of the policy or, for a policy for a term longer than one (1) year and not having a fixed expiration date, sixty (60) days prior to the anniversary date; and

- (8) Policies containing an exclusion for punitive damages must include a definition of punitive damages substantially similar to the following: "Punitive damages" are damages that may be imposed to punish a wrongdoer and to deter others from similar conduct.

23-79-308. Noncomplying provisions.

Any commercial property and casualty insurance policy, contract, rider, or endorsement issued after March 13, 1987, and otherwise valid that contains any condition or provision not in compliance with the requirements of this subchapter shall be construed and applied in accordance with the provisions of this subchapter.

23-79-309. Administrative procedures - Appeals.

- (a) Administrative procedures exercised by the Insurance Commissioner under this subchapter shall be in accordance with §§ 23-61-303 - 23-61-306.
- (b) Appeals from orders of the commissioner made under this subchapter shall be made in accordance with § 23-61-307.

23-79-310. Rules and regulations.

The Insurance Commissioner may promulgate such reasonable rules and regulations as are necessary to carry out the provisions of this subchapter.

23-79-311. Motor vehicle liability insurance - Extraterritorial provision.

- (a)(1) Motor vehicle liability insurance applies to the amounts which the owner is legally obligated to pay as damages because of accidental bodily injury and accidental property damage arising out of the ownership or operation of a motor vehicle if the accident occurs in the United States, its possessions, or Canada.
- (2) Motor vehicle liability insurance must afford limits of liability not less than those required under the financial responsibility laws of the jurisdiction of this state.
- (b) If the accident occurs outside this state but in the United States, its possessions, or Canada and if the limits of liability of the financial responsibility or compulsory insurance laws of the applicable jurisdiction exceed the limits of liability of the financial responsibility laws of this state, the motor vehicle liability insurance is deemed to comply with the limits of liability of the laws of the applicable jurisdiction.
- (c) For purposes of this section, "motor vehicle" is defined as provided in § 27-14-207.

23-79-312. Motor vehicle liability insurance - Prohibition regarding step-downs.

No motor vehicle liability insurance policy issued or delivered in this state shall contain a provision that converts the limits for bodily injury or property damage to lower limits in the event that the insured motor vehicle is involved in an accident while it is being driven by a driver other than the insured.

Subchapter 4. Medicare Supplement Insurance Minimum Standards Act.

23-79-401. Title.

This subchapter shall be known and cited as the "Medicare Supplement Insurance Minimum Standards Act".

23-79-402. Applicability and scope.

- (a) Except as otherwise specifically provided in § 23-79-405, this subchapter shall apply to:
 - (1) All medicare supplement policies delivered or issued for delivery in this state on or after March 20, 1992; and
 - (2) All certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this state.
- (b) This subchapter shall not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.
- (c) The provisions of this subchapter are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to medicare eligible persons, which policies are not marketed or held to be medicare supplement policies or benefit plans.

23-79-403. Definitions.

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

- (1) "Applicant" means:
 - (A) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and
 - (B) In the case of a group medicare supplement policy, the proposed certificate holder;
- (2) "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy;
- (3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer;
- (4) "Commissioner" means the Insurance Commissioner of the State of Arkansas;
- (5) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates;
- (6) "Medicare" means the "Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;
- (7) "Medicare supplement policy" means a group or individual policy of accident and health insurance, a subscriber contract of a hospital and medical service corporation or health maintenance organization other than a policy issued

- pursuant to a contract under section 1876 or section 1833 of the federal Social Security Act, or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare; and
- (8) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

23-79-404. Standards for policy provisions and authority to promulgate regulations.

- (a) No medicare supplement policy or certificate in force in this state shall contain benefits that duplicate benefits provided by Medicare.
- (b) Notwithstanding any other provision of law of this state, a medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
- (c) The Insurance Commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state, including §§ 23-66-306, 23-79-109 and 23-79-112. No requirement of the Arkansas Insurance Code, § 23-60-101 et seq., relating to minimum required policy benefits, other than the minimum standards contained in this subchapter, shall apply to medicare supplement policies and certificates. The standards may cover, but not be limited to:
- (1) Terms of renewability;
 - (2) Initial and subsequent conditions of eligibility;
 - (3) Nonduplication of coverage;
 - (4) Probationary periods;
 - (5) Benefit limitations, exceptions, and reductions;
 - (6) Elimination periods;
 - (7) Requirements for replacement;
 - (8) Recurrent conditions; and
 - (9) Definitions of terms.
- (d) The commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements, and reporting practices for medicare supplement policies and certificates.
- (e) The commissioner may adopt, from time to time, such reasonable regulations as are necessary to conform medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including but not limited to:

- (1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;
 - (2) Establishing a uniform methodology for calculating and reporting loss ratios;
 - (3) Assuring public access to policies, premiums, and loss ratio information of issuers of medicare supplement insurance;
 - (4) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;
 - (5) Establishing a policy for holding public hearings prior to approval of premium increases; and
 - (6) Establishing standards for Medicare Select policies and certificates.
- (f) The commissioner may adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a medicare supplement policy or certificate.

23-79-405. Loss ratio standards.

Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premiums charged. The Insurance Commissioner shall issue reasonable regulations to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

23-79-406. Disclosure standards.

- (a) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.
- (b) The Insurance Commissioner shall prescribe the format and content of the outline of coverage required by subsection (a) of this section. For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type, and arrangement of text and captions. Such outline of coverage shall include:
 - (1) A description of the principal benefits and coverage provided in the policy;
 - (2) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums, and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and
 - (3) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.
- (c) The commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for Medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the

buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

- (d) The commissioner may adopt regulations for captions or notice requirements determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages for all accident and health insurance policies sold to persons eligible for Medicare by reason of age, other than:
 - (1) Medicare supplement policies;
 - (2) Disability income policies;
 - (3) Basic, catastrophic, or major medical expense policies; or
 - (4) Single premium, nonrenewable policies.
- (e) The commissioner may adopt reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of accident and health policies, subscriber contracts, or certificates by persons eligible for Medicare.

23-79-407. Notice of free examination.

Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

23-79-408. Filing requirements for advertising.

Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement advertising intended for use in this state whether through written, radio, or television medium to the Insurance Commissioner for review and approval prior to its use in this state.

23-79-409. Administrative procedures.

Regulations adopted pursuant to this subchapter shall be subject to the provisions of § 23-61-108 and to the provisions of § 25-15-201 et seq.

23-79-410. Penalties.

In addition to any other applicable penalties for violations of the Arkansas Insurance Code, § 23-60-101 et seq., the Insurance Commissioner may require issuers violating any provisions of this subchapter or regulations promulgated pursuant to this subchapter to cease marketing any Medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require such issuer to take such actions

as are necessary to comply with the provisions of this subchapter, or both.

Subchapter 5. Comprehensive Health Insurance Pool Act.

23-79-501. Purpose.

- (a) Act 1339 of 1995 established the Arkansas Comprehensive Health Insurance Pool as a state program that was intended to provide an alternate market for health insurance for certain uninsurable Arkansas residents, and further this subchapter is intended to provide for the successor entity that will provide the acceptable alternative mechanism as described in the federal Health Insurance Portability and Accountability Act of 1996 for providing portable and accessible individual health insurance coverage for federally eligible individuals as defined in this subchapter.
- (b) The General Assembly declares that it intends for this program to provide portable and accessible individual health insurance coverage for every federally eligible individual who qualifies for coverage in accordance with § 23-79-509(b), but does not intend for every eligible person who qualifies for pool coverage in accordance with § 23-79-509 to be guaranteed a right to be issued a policy under this pool as a matter of entitlement.

23-79-502. Short title.

This subchapter may be cited as the "Comprehensive Health Insurance Pool Act", and is amendatory to the Arkansas Insurance Code, § 23-60-101 et seq., and the provisions of the Arkansas Insurance Code which are not in conflict with this subchapter are applicable to this subchapter.

23-79-503. Definitions.

For the purposes of this subchapter, the following definitions apply:

- (1) "Agent" means any person who is licensed to sell health insurance in this state;
- (2) "Board" means the Board of Directors of the Arkansas Comprehensive Health Insurance Pool;
- (3) "Church plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;
- (4) "Commissioner" means the Insurance Commissioner for the State of Arkansas;
- (5) "Continuation coverage" means continuation of coverage under a group health plan or other health insurance coverage for former employees or dependents of former employees that would otherwise have terminated under the terms of that coverage pursuant to any continuation provisions under federal or state law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, § 23-86-114 of the Arkansas Insurance Code, § 23-60-101 et seq., or any other similar requirement in another state;
- (6) "Covered person" means a person who is and continues to remain eligible for pool coverage and is covered under one (1) of the plans offered by the pool;
- (7)(A) "Creditable coverage" means, with respect to a federally eligible individual, coverage of the individual under any of the following:

- (i) A group health plan;
- (ii) Health insurance coverage, including group health insurance coverage;
- (iii) Medicare;
- (iv) Medical assistance;
- (v) 10 U.S.C. § 1071 et seq.;
- (vi) A medical care program of the Indian Health Service or of a tribal organization;
- (vii) A state health benefits risk pool;
- (viii) A health plan offered under 5 U.S.C. § 8901 et seq.;
- (ix) A public health plan, as defined in regulations consistent with § 104 of the Health Care Portability and Accountability Act of 1996 that may be promulgated by the Secretary of the Department of Health and Human Services; and
- (x) A health benefit plan under § 5(e) of the Peace Corps Act, 22 U.S.C. § 2504(e).

(B) Creditable coverage does not include:

- (i) Coverage consisting solely of coverage of excepted benefits as defined in § 2791(C) of Title XXVII of the Public Health Services Act, 42 U.S.C. § 300(gg-91); or
- (ii)(a) Any period of coverage under subdivisions (7)(A)(i)-(x) of this section that occurred before a break of more than sixty-three (63) days during all of which the individual was not covered under subdivisions (7)(A)(i)-(x) of this section.
 - (b) Any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into account in determining if there has been a break of more than sixty-three (63) days in any creditable coverage;

(8) "Department" means the State Insurance Department;

(9) "Excess or stop-loss coverage" means an arrangement whereby an insurer insures against the risk that any one (1) claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount;

(10) "Federally eligible individual" means an individual resident of Arkansas:

- (A)(i) For whom, as of the date on which the individual seeks pool coverage under § 23-79-509, the aggregate of the periods of creditable coverage is eighteen (18) or more months; and
- (ii) Whose most recent prior creditable coverage was under group health insurance coverage offered by an insurer, a group health plan, a governmental plan, or a church plan, or health insurance coverage offered in connection with any such plans;

(B) Who is not eligible for coverage under:

- (i) A group health plan;
- (ii) Part A or Part B of Medicare; or

- (iii) Medical assistance and does not have other health insurance coverage;
 - (C) With respect to whom the most recent coverage within the coverage period described in subdivision (10)(A)(i) of this section was not terminated based upon a factor related to nonpayment of premiums or fraud;
 - (D) If the individual has been offered the option of continuation coverage under a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation provision or under a similar state program, who elected such coverage; and
 - (E) Who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program;
- (11) "Group health plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;
- (12) "Governmental plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;
- (13)(A) "Health insurance" means any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, hospital or medical service corporation, health maintenance organization, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.
- (B) The term does not include long-term care, disability income, short-term, accident, dental-only, vision-only, fixed indemnity, limited-benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- (14) "Health maintenance organization" shall have the same meaning as defined in § 23-76-102;
- (15) "Hospital" shall have the same meaning as defined in § 20-9-201;
- (16) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance;
- (17) "Insurer" means any entity that provides health insurance, including excess or stop-loss health insurance in the State of Arkansas. For the purposes of this subchapter, "insurer" includes an insurance company, medical services plans, hospital plans, hospital medical service corporations, health maintenance organizations, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;
- (18) "Medical assistance" means the state medical assistance program provided under Title XIX of the Social Security Act or under any similar program of health care benefits in a state other than Arkansas;
- (19)(A) "Medically necessary" means that a service, drug, supply, or article is necessary and appropriate for the diagnosis or treatment of an illness or injury in accord with generally accepted standards of medical practice at the time the service, drug, or supply is provided. When specifically applied to a confinement it

further means the diagnosis or treatment of the covered person's medical symptoms or condition cannot be safely provided to that person as an outpatient.

- (B) A service, drug, supply, or article shall not be medically necessary if it:
- (i) Is investigational, experimental, or for research purposes;
 - (ii) Is provided solely for the convenience of the patient, the patient's family, physician, hospital, or any other provider;
 - (iii) Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;
 - (iv) Could have been omitted without adversely affecting the covered person's condition or the quality of medical care; or
 - (v) Involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration;
- (20) "Medicare" means coverage under Part A and Part B of Title XVII of the Social Security Act, 42 U.S.C. § 1395 et seq.;
- (21) "Physician" means a person licensed to practice medicine as duly licensed by the State of Arkansas;
- (22) "Plan" means the comprehensive health insurance plan as adopted by the board or by rule;
- (23) "Plan administrator" means the insurer designated under § 23-79-508 to carry out the provisions of the plan of operation;
- (24) "Plan of operation" means the plan of operation of the pool, including articles, bylaws, and operating rules adopted by the board pursuant to this subchapter;
- (25) "Provider" means any hospital, skilled nursing facility, hospice, home health agency, physician, pharmacist, or any other person or entity licensed in Arkansas to furnish medical care, articles and supplies;
- (26) "Qualified high risk pool" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996; and
- (27) "Resident eligible person" means a person who:
- (A) Has been legally domiciled in the State of Arkansas for a period of at least thirty (30) days and continues to be domiciled in Arkansas; and
 - (B) Is not eligible for coverage under:
 - (i) A group health plan;
 - (ii) Part A or Part B of Medicare; or
 - (iii) Medical assistance as defined in this section and does not have other health insurance coverage as defined in this section.

23-79-504. Arkansas Comprehensive Health Insurance Pool.

- (a) There is hereby created a nonprofit legal entity to be known as the "Arkansas Comprehensive Health Insurance Pool" as the successor entity to the nonprofit legal entity established by Act 1339 of 1995.
- (b)(1) The pool shall operate subject to the supervision and control of the Board of Directors of the Arkansas Comprehensive Health Insurance Pool. The pool is created as a political subdivision, instrumentality, and body politic of the State of Arkansas, and, as such, is not a state agency.

- (2) The pool will be exempt from all state, county, and local taxes, § 19-11-201 et seq., § 25-19-101 et seq., and § 25-15-201 et seq., except to the extent defined in this subchapter.
 - (3) The board shall consist of the following seven (7) members to be appointed by the Insurance Commissioner:
 - (A) Two (2) current or former representatives of insurance companies licensed to do business in the State of Arkansas;
 - (B) Two (2) current or former representatives of health maintenance organizations licensed to do business in the State of Arkansas;
 - (C) One (1) member of a health-related profession licensed in the State of Arkansas;
 - (D) One (1) member from the general public who is not associated with the medical profession, a hospital, or an insurer; and
 - (E) One (1) member to represent a group considered to be uninsurable.
 - (4) In making appointments to the board, the commissioner shall strive to ensure that at least one (1) person serving on the board is at least sixty (60) years of age.
 - (5) All terms shall be for three (3) years.
 - (6) The board shall elect one (1) of its members as chairman.
 - (7) Any vacancy in the board occurring for any reason other than the expiration of a term shall be filled for the unexpired term in the same manner as the original appointment.
 - (8) Members of the board may be reimbursed from moneys of the pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the board but shall not otherwise be compensated for their services.
- (c) All insurers, as a condition of doing business in the State of Arkansas, shall participate in the pool by paying the assessments, submitting the reports, and providing the information required by the board or the commissioner to implement the provisions of this subchapter.
- (d) Neither the board nor its employees shall be liable for any obligations of the pool. No board member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this subchapter. The board may provide in its bylaws or rules for indemnification of, and legal representation for, the board members and employees.

23-79-505. Plan of operation.

- (a)(1) The Board of Directors of the Arkansas Comprehensive Health Insurance Pool shall adopt a plan of operation pursuant to this subchapter and shall submit to the Insurance Commissioner for approval the plan of operation including the pool's articles, bylaws and operating rules, and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The plan of operation shall become effective upon approval in writing by the commissioner.
- (2) If the board fails to submit a suitable plan of operation within one hundred eighty

- (180) days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of this section. The rules shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner.
- (b) The plan of operation shall:
- (1) Establish procedures for operation of the pool;
 - (2) Establish procedures for selecting a plan administrator in accordance with § 23-79-508 of this subchapter;
 - (3) Create a fund, under management of the board, to pay administrative claims and other expenses of the pool;
 - (4) Establish procedures for the handling, accounting and auditing of assets, moneys and claims of the pool and the plan administrator;
 - (5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan;
 - (6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board after completion of the review. The board shall retain all written complaints regarding the plan for at least three (3) years; and
 - (7) Provide for other matters as may be necessary and proper for the execution of the board's powers, duties and obligations under this subchapter.

23-79-506. Powers.

- (a) The Arkansas Comprehensive Health Insurance Pool shall have the general powers and authority granted under the laws of the State of Arkansas to health insurers and, in addition thereto, the specific authority to:
- (1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this subchapter;
 - (2) Sue or be sued, including taking any legal actions necessary or proper;
 - (3) Take such legal action as necessary, including but not limited to:
 - (A) Avoiding the payment of improper claims against the pool or the coverage provided by or through the pool;
 - (B) Recovering any amounts erroneously or improperly paid by the pool;
 - (C) Recovering any amounts paid by the pool as a result of mistake of fact or law;
 - (D) Recovering other amounts due the pool; or
 - (E) Coordinating legal action with the Insurance Commissioner to enforce the provisions of this subchapter;
 - (4)(A) Establish and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas, deductibles, copayments, coinsurance, and any other actuarial function

appropriate to the operation of the pool.

- (B) Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographical variation in claim costs and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;
 - (5) Issue policies of insurance in accordance with the requirements of this subchapter. All policy forms shall be subject to the approval of the commissioner;
 - (6) Authorize the plan administrator to prepare and distribute certificate of eligibility forms and enrollment instruction forms to agents and to the general public;
 - (7) Provide for and employ cost-containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purposes of making the plan more cost effective;
 - (8) Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting directly or through the plan administrator with preferred provider organizations, health maintenance organizations, physician hospital organizations, or other limited network provider arrangements;
 - (9) Borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets;
 - (10) Pledge, assign, and grant a security interest in any of the assessments authorized by this subchapter or other assets of the pool in order to secure any notes or other evidences of indebtedness of the pool;
 - (11) Provide for reinsurance of risks incurred by the pool;
 - (12) Provide additional types of plans to provide optional coverages, including medicare supplement health insurance;
 - (13) Enter into reciprocal agreements with other comparable state plans in order to provide coverage for persons who move between states and are covered by such other states' plans; and
 - (14) In addition to the other powers granted by the Arkansas Insurance Code, § 23-60-101 et seq., the commissioner may, after notice and hearing in accordance with the provisions of the Arkansas Insurance Code, § 23-60-101 et seq., impose a monetary penalty upon any insurer or suspend or revoke the certificate of authority to transact insurance in the State of Arkansas of any insurer who fails to pay an assessment or otherwise file any report or furnish information required to be filed with the Board of Directors of the Arkansas Comprehensive Health Insurance Pool pursuant to the board's direction that the board believes is necessary in order for the board to perform its duties under this subchapter.
- (b) All outstanding contracts executed by the Board of Directors of the State Comprehensive Health Insurance Pool created by Act 1339 of 1995 shall be deemed continuing obligations of the board created by this subchapter.
 - (c) As provided for in § 23-79-502, any health insurance benefit not provided for in this subchapter shall be deemed to be in conflict with and therefore inapplicable to the provisions of this subchapter.

23-79-507. Funding of pool.

(a) Premiums.

- (1) The Arkansas Comprehensive Health Insurance Pool shall establish premium rates for plan coverage as provided in subdivision (a)(2) of this section. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the Insurance Commissioner for approval prior to use.
- (2)(A) The pool, with the assistance of the commissioner, shall determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals in Arkansas. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage.
- (B) Initial rates for plan coverage shall not be less than one hundred fifty percent (150%) of rates established as applicable for individual standard risks in Arkansas. Subject to the limits provided in this subdivision (a)(2), subsequent rates shall be established to help provide for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall plan rates exceed two hundred percent (200%) of rates applicable to individual standard risks.

(b) Sources of Additional Revenue.

- (1) In addition to the powers enumerated in § 23-79-506, the pool shall have the authority to assess insurers in accordance with the provisions of this section and to make advance interim assessments as may be reasonable and necessary for the pool's organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year.
- (2) Following the close of each fiscal year, the plan administrator shall determine the net premiums, i.e., premiums less administrative expense allowances, the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. The deficit incurred by the pool shall be recouped by assessments apportioned by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool among insurers.
- (3) Each insurer's assessment shall be determined by multiplying the total assessment of all insurers as determined in subdivision (b)(2) of this section by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all health insurance premiums by all insurers.
- (4) If assessments exceed the pool's actual losses and administrative expenses, the excess shall be held at interest and used by the board to offset future losses or to reduce future assessments. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.
- (5) Each insurer's assessment shall be determined annually by the board based on

annual statements and other reports deemed necessary by the board and filed by the insurer with the board or the commissioner.

- (6)(A) An insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer, in whole or in part, the assessment if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations.
- (B) In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred shall be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this subsection. The insurer receiving the abatement or deferment shall remain liable to the plan for the deficiency for four (4) years.
- (7) From July 1, 1997, until December 31, 1997, if the board issues an assessment upon insurers, the board will utilize the method of calculating the assessment consistent with the provisions set forth in this subchapter, provided however, for purposes of this interim period assessment, insurers shall be defined as any individual, corporation, association, partnership, fraternal benefits society, or any other entity engaged in the health insurance business, except insurance agents or brokers. This term shall also include medical services plans, hospital plans, health maintenance organizations, and self-insurance arrangements, which shall be designated as engaged in the business of insurance for the purposes of this interim period assessment. For all assessments issued by the board, beginning January 1, 1998, only those individuals, corporations, associations, or other entities defined as an insurer in § 23-79-503(17) shall be subject to assessment.
- (8) In the event the board fails to act within a reasonable period of time to recoup by assessment any deficit incurred by the pool, the commissioner shall have all the powers and duties of the board under this chapter with respect to assessing insurers.

(c) Assessment Offsets.

- (1)(A) Any assessment may be offset in an amount equal to the amount of the assessment paid to the pool against the premium tax payable by that insurer for the year in which the assessment is levied or for the four (4) years subsequent to that year.
- (B) No offset shall be allowed for any penalty assessed under subdivision (d)(1) of this section.
- (2) Notwithstanding any provisions of this subchapter to the contrary, no insurer may be assessed in any one (1) calendar year an amount greater than the amount which that insurer paid to the state in the previous year as premium tax on the business to which this tax applies, or one-hundredth of one percent (0.01%) of the total written premiums on the business in this state, whichever is greater.
- (d)(1) All assessments and fees shall be due and payable upon receipt and shall be delinquent if not paid within thirty (30) days of the receipt of the notice by the insurer. Failure to timely pay the assessment will automatically subject the insurer to a ten percent (10%) penalty, which will be due and payable within the next thirty-day

period. The board and the commissioner shall have the authority to enforce the collection of the assessment and penalty in accordance with the provisions of this subchapter and the Arkansas Insurance Code, § 23-60-101 et seq. The board may waive the penalty authorized by this subsection if it determines that compelling circumstances exist which justify such waiver.

(2) The board and the commissioner shall have the authority to enforce the collection of the assessment and penalty in accordance with the provisions of this subchapter and the Arkansas Insurance Code, § 23-60-101 et seq. The board may waive the penalty authorized by this subsection if it determines that compelling circumstances exist which justify the waiver.

23-79-508. Plan administrator.

- (a) The Board of Directors of the Arkansas Comprehensive Health Insurance Pool shall select an insurer through a competitive bidding process to administer the plan; provided, however, that the administering insurer designated by the board created by Act 1339 of 1995 shall serve as the plan administrator under this subchapter until the expiration of the current contract of the administering insurer. The board shall evaluate bids submitted under this section based upon criteria established by the board which shall include, but not be limited to, the following:
- (1) The plan administrator's proven ability to handle large group accident and health benefit plans;
 - (2) The efficiency and timeliness of the plan administrator's claim processing procedures;
 - (3) An estimate of total charges for administering the plan;
 - (4) The plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost efficient manner; and
 - (5) The financial condition and stability of the plan administrator.
- (b)(1) The plan administrator shall serve for a period of three (3) years subject to removal for cause and subject to the terms, conditions, and limitations of the contract between the board and the plan administrator.
- (2) The board shall advertise for and accept bids to serve as the plan administrator for the succeeding three-year periods.
- (c) The plan administrator shall perform functions related to the plan as may be assigned to it including:
- (1) Determination of eligibility;
 - (2) Payment and processing of claims;
 - (3) Establishment of a premium billing procedure for collection of premiums. Billings shall be made on a periodic basis as determined by the board; and
 - (4) Other necessary functions to assure timely payment of benefits to covered persons under the plan, including:
 - (A) Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made; and
 - (B) Evaluating the eligibility of each claim for payment under the plan.

- (d)(1) The plan administrator shall submit regular reports to the board regarding the operation of the plan.
 - (2) Frequency, content, and form of the report shall be determined by the board.
- (e)(1) The plan administrator shall pay claim expenses from the premium payments received from or on behalf of plan participants and allocated by the board for claim expenses.
 - (2) If the plan administrator's payments for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide additional funds to the plan administrator for payment of claims expenses.
- (f) The plan administrator shall be governed by the requirements of this subchapter and shall be compensated as provided in the contract between the board and the plan administrator.

23-79-509. Plan eligibility.

- (a) **Resident Eligible Person.** The following requirements apply to a resident eligible person in order for the person to be eligible for plan coverage:
 - (1) Except as provided in subdivision (a)(2) or subsection (b) of this section, any individual person who meets the definition of resident eligible person as defined by § 23-79-503(27) and is either a citizen of the United States or an alien lawfully admitted for permanent residence who continues to be a resident of this state shall be eligible for plan coverage if evidence is provided of:
 - (A) A notice of rejection or refusal by an insurer to issue substantially similar individual health insurance coverage by reason of the existence or history of a medical condition or upon such other evidence the Board of Directors of the Arkansas Comprehensive Health Insurance Pool deems sufficient in order to verify that the applicant is unable to obtain the coverage from an insurer due to the existence or history of a medical condition; or
 - (B)(i) A refusal by an insurer to issue individual health insurance coverage, except at a rate which the board determines is substantially in excess of the applicable plan rate.
 - (ii) A rejection or refusal by a group health plan or insurer offering only stop-loss or excess-of-loss insurance or contracts, agreements, or other arrangements for reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection;
 - (2) A person shall not be eligible for coverage under the plan if:
 - (A) The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy or would be eligible to have coverage if the person elected to obtain it, except that:
 - (i) A person may maintain other coverage for the period of time the person is satisfying any waiting period for a preexisting condition under a plan policy; and
 - (ii) A person may maintain plan coverage for the period of time the person is satisfying a waiting period for a preexisting condition under another health insurance policy intended to replace the plan policy;

- (B) The person is determined to be eligible for health care benefits under Title XIX of the Social Security Act;
 - (C) The person has previously terminated plan coverage unless twelve (12) months have elapsed since termination of coverage;
 - (D) The person fails to pay the required premium under the covered person's terms of enrollment and participation, in which event the liability of the plan shall be limited to benefits incurred under the plan for the same period for which premiums had been paid and the covered person remained eligible for plan coverage;
 - (E) The plan has paid a total of one million dollars (\$1,000,000) in benefits on behalf of the covered person;
 - (F) The person is a resident of a public institution; or
 - (G) The person's premium is paid for or reimbursed under any government-sponsored program or by any government agency, foundation, health care facility, or health care provider, except as an otherwise qualifying full-time employee or dependent of such an employee of a government agency, foundation, health care facility, or health care provider;
- (3) The board or the plan administrator shall require verification of residency and may require any additional information, documentation, or statements under oath whenever necessary to determine plan eligibility or residency;
- (4) Coverage shall cease:
- (A) On the date a person is no longer a resident of the State of Arkansas;
 - (B) On the date a person requests coverage to end;
 - (C) On the death of the covered person;
 - (D) On the date state law requires cancellation of the policy; or
 - (E) At the plan's option, thirty (30) days after the plan makes any written inquiry concerning a person's eligibility or place of residence to which the person does not reply; and
- (5) Except under the conditions set forth in subdivision (a)(4) of this section, the coverage of any person who ceases to meet the eligibility requirements of this section shall be terminated at the end of the current policy period for which the necessary premiums have been paid.
- (b) **Federally Eligible Individual.** The following requirements apply to a federally eligible individual in order for such individual to be eligible for plan coverage:
- (1) Notwithstanding the requirements of subsection (a) of this section, any federally eligible individual for whom a plan application, and such enclosures and supporting documentation as the board may require, is received by the board within sixty-three (63) days after the termination of prior creditable coverage for reasons other than nonpayment of premium or fraud that covered the applicant shall qualify to enroll in the plan under the portability provisions of this subsection;
 - (2) Any federally eligible individual seeking plan coverage under this subsection must submit with his or her application evidence, including acceptable written certification of previous creditable coverage, that will establish to the board's

- satisfaction that he or she meets all of the requirements to be a federally eligible individual and is currently and permanently residing in the State of Arkansas as of the date his or her application was received by the board;
- (3) A period of creditable coverage shall not be counted, with respect to qualifying an applicant for plan coverage as a federally eligible individual under this subsection, if after such period and before the application for plan coverage was received by the board, there was at least a sixty-three-day period during all of which the individual was not covered under any creditable coverage;
 - (4) Any federally eligible individual who the board determines qualifies for plan coverage under this subsection shall be offered his or her choice of enrolling in one of the alternative portability plans which the board is authorized under this subsection to establish for these federally eligible individuals;
 - (5)(A) The board shall offer a choice of health-care coverages consistent with major medical coverage under the alternative plans authorized by this subsection to every federally eligible individual. The coverages to be offered under the plans, the schedule of benefits, deductibles, copayments, coinsurance, exclusions, and other limitations shall be approved by the board.
 - (B) One (1) optional form of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in the State of Arkansas or a standard option of coverage available under the individual health insurance laws of the State of Arkansas. The standard plan that is authorized by § 23-79-510 may be used for this purpose.
 - (C) The board may also offer a preferred provider option and such other options as the board determines may be appropriate for these federally eligible individuals who qualify for plan coverage pursuant to this subsection;
 - (6) Notwithstanding the requirements of § 23-79-510(f), any plan coverage that is issued to federally eligible individuals who qualify for plan coverage pursuant to the portability provisions of this subsection shall not be subject to any preexisting conditions exclusion, waiting period, or other similar limitation on coverage;
 - (7) Federally eligible individuals who qualify and enroll in the plan pursuant to this subsection shall be required to pay such premium rates as the board shall establish and approve in accordance with the requirements of § 23-79-507(a); and
 - (8) A federally eligible individual who qualifies and enrolls in the plan pursuant to this subsection must continue to satisfy all of the other eligibility requirements of this subchapter to the extent not inconsistent with the federal Health Insurance Portability and Accountability Act of 1996 in order to maintain continued eligibility for coverage under the plan.
- (c) Any person who was issued a policy pursuant to the provisions of Act 1339 of 1995 shall be deemed continuously covered consistent with the terms of this subchapter and reissued a new policy in accordance with the provisions of this subchapter.

23-79-510. Outline of benefits.

- (a)(1) Subject to the contractual policy form language adopted by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool, expenses for the following services, supplies, drugs, or articles when prescribed by a physician and determined

by the plan to be medically necessary shall be covered, subject to provisions of subsection (b) of this section:

- (A) Hospital services;
 - (B) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction;
 - (C) Drugs requiring a physician's prescription;
 - (D) Skilled nursing services of a licensed skilled nursing facility for not more than one hundred twenty (120) days during a policy year;
 - (E) Services of a home health agency up to a maximum of two hundred seventy (270) services per year;
 - (F) Use of radium or other radioactive materials;
 - (G) Oxygen;
 - (H) Prostheses other than dental;
 - (I) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which such equipment is prescribed;
 - (J) Diagnostic X rays and laboratory tests;
 - (K) Oral surgery for excision of partially or completed unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;
 - (L) Services of a physical therapist;
 - (M) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest facility qualified to treat a covered condition;
 - (N) Services for diagnosis and treatment of mental and nervous disorders or chemical and drug dependency provided that a covered person shall be required to make a fifty percent (50%) copayment and that the plan's payment shall not exceed four thousand dollars (\$4,000) annually; and
 - (O) Such additional benefits deemed appropriate by the board in accordance with the provisions of subsection (b) of this section.
- (2) **Exclusions.** Subject to the contractual policy form language adopted by the board, the following services, supplies, drugs or articles whether prescribed by a physician or not shall not be covered:
- (A) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;
 - (B) Care which is primarily for custodial or domiciliary purposes;
 - (C) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is medically necessary;
 - (D) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary;

- (E) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;
- (F) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred;
- (G) Dental care except as provided in subdivision (a)(1)(K) of this section;
- (H) Eyeglasses and hearing aids;
- (I) Illness or injury due to acts of war;
- (J) Services of blood donors and any fee for failure to replace the first three (3) pints of blood provided to a covered person each policy year;
- (K) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service;
- (L) Routine maternity charges for a pregnancy, except where added as optional coverage with payment of additional premiums;
- (M) Any expense or charge for services, articles, drugs, or supplies that are not provided in accord with generally accepted standards of current medical practice;
- (N) Any expense or charge for routine physical examinations or tests;
- (O) Any expense for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay;
- (P) Any expense incurred for benefits provided under the laws of the United States and the State of Arkansas, including Medicare and Medicaid and other medical assistance, military service-connected disability payments, medical services provided for members of the armed forces and their dependents or employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States;
- (Q) Any expense or charge for in vitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy;
- (R) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures;
- (S) Any expense or charge for sterilization or sterilization reversals;
- (T) Any expense or charge for weight-loss programs, exercise equipment, or treatment of obesity, except when certified by a physician as morbid obesity, i.e., at least two (2) times normal body weight;
- (U) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery;
- (V) Any expense or charge for organ or bone marrow transplants other than those performed at a hospital with a board-approved organ transplant program that has been designated by the board as a preferred provider organization for that specific organ or bone marrow transplant;
- (W) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical specialty

college for general use within the medical community; and

- (X) Such additional exclusions deemed appropriate by the board in accordance with the provisions of subsection (b) of this section.
- (b) In establishing the plan coverage, the board shall take into consideration the levels of health insurance provided in the state and medical economic factors as may be deemed appropriate and promulgate benefits, deductibles, copayments, coinsurance factors, exclusions, and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.
- (c) The board may adjust any deductibles, copayments and coinsurance factors annually according to the medical component of the Consumer Price Index.
- (d) **Nonduplication of Benefits.**
- (1)(A) The pool shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available.
- (B) Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance or any other source providing benefits because of a sickness or injury and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.
- (2) The pool shall have a cause of action against a covered person for the recovery of the amount of benefits paid that are not covered by the pool. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this subdivision.
- (e) **Right of Subrogation - Recoveries.**
- (1)(A) Whenever the pool has paid benefits because of sickness or an injury to any covered person resulting from a third party's wrongful act or negligence, or for which an insurance company or self-insured entity is liable in accordance with the provisions of any policy of insurance, and the covered person has recovered or may recover damages from a third party that is liable for damages, the pool shall have the right to recover the benefits it paid from any amounts that the covered person has received or may receive regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from the sickness or injury.
- (B) The pool shall be subrogated to any right of recovery the covered person may have under the terms of any private or public health care coverage or liability coverage, including coverage under a workers' compensation act without the necessity of assignment of claim or other authorization to secure the right of recovery.
- (C) To enforce its subrogation right, the pool may:
- (i) Intervene or join in an action or proceeding brought by the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, against any third party or the third party's

- insurance carrier or self-insured entity that may be liable; or
- (ii) Institute and prosecute legal proceedings against any third party or the third party's insurance carrier or self-insured entity that may be liable for the sickness or injury in an appropriate court either in the name of the pool or in the name of the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors.
- (2)(A)(i) If any action or claim is brought by or on behalf of a covered person against a third party or the third party's insurance carrier or self-insured entity, the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, shall notify the pool by personal service or registered mail of the action or claim and of the name of the court in which the action or claim is brought, filing proof thereof in the action or claim.
- (ii) The pool may, at any time thereafter, join in the action or claim upon its motion so that all orders of court after hearing and judgment shall be made for its protection.
- (B) No release or settlement of a claim for damages and no satisfaction of judgment in the action shall be valid without the written consent of the pool to the extent of its interest in the settlement or judgment and of the covered person or his personal representative.
- (3)(A) In the event that the covered person or his personal representative fails to institute a proceeding against any appropriate third party before the fifth month before the action would be barred, the pool may, in its own name or in the name of the covered person or personal representative, commence a proceeding against any appropriate third party for the recovery of damages on account of any sickness, injury, or death to the covered person.
- (B) The covered person shall cooperate in doing what is reasonably necessary to assist the pool in any recovery and shall not take any action that would prejudice the pool's right to recovery.
- (C) The pool shall pay to the covered person or his personal representative all sums collected from any third party by judgment or otherwise in excess of amounts paid in benefits under the pool and amounts paid or to be paid as costs, attorney's fees, and reasonable expenses incurred by the pool in making the collection or enforcing the judgment.
- (4)(A)(i) In the event of judgment or award in either a suit or claim against a third party, the court shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees.
- (ii) After payment of those expenses and attorney's fees, the court shall apply out of the balance of the judgment or award an amount sufficient to reimburse the pool the full amount of benefits paid on behalf of the covered person under this subchapter, provided the court may reduce and apportion the pool's portion of the judgment proportionately to the recovery of the covered person.
- (B)(i) The burden of producing sufficient evidence to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be

enforced against the recovery shall rest with the party seeking the reduction.

(ii) The court may consider the nature and extent of the injury, economic and noneconomic loss, settlement offers, comparative or contributory negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs.

(C) The pool shall pay its pro rata share of the attorney's fees based on the pool's recovery as it compares to the total judgment.

(D) Any reimbursement rights of the pool shall take priority over all other liens and charges existing under the laws of the State of Arkansas.

(5) The pool may compromise or settle and release any claim for benefits provided under this subchapter or waive any claims for benefits, in whole or in part, for the convenience of the pool or if the pool determines that collection will result in undue hardship upon the covered person.

(f) Preexisting Conditions.

(1) Except for federally eligible individuals qualifying for plan coverage under § 23-79-509(b) or resident eligible persons who qualify for and elect to purchase the waiver authorized in subdivision (f)(2) of this section, plan coverage shall exclude charges or expenses incurred during the first six (6) months following the effective date of coverage as to any condition if:

(A) The condition has manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinary prudent person to seek diagnosis, care, or treatment; or

(B) Medical advice, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of the coverage.

(2) **Waiver.** The preexisting condition exclusions as set forth in subdivision (f)(1) of this section will be waived to the extent to which the resident eligible person:

(A) Has satisfied similar exclusions under any prior health insurance coverage or group health plan that was involuntarily terminated;

(B) Is ineligible for any continuation coverage that would continue or provide substantially similar coverage following that termination; and

(C) Has applied for plan coverage not later than thirty (30) days following the involuntary termination. For each resident eligible person who qualifies for and elects this waiver, there shall be added to each payment of premium, on a prorated basis, a surcharge of up to ten percent (10%) of the otherwise applicable annual premium for as long as that individual's coverage under the plan remains in effect or sixty (60) months, whichever is less.

(3)(A) Whenever benefits are due from the plan because of sickness or an injury to a covered person resulting from a third party's wrongful act or negligence and the covered person has recovered or may recover damages from a third party or its insurance carrier or self-insured entity, the plan shall have the right to reduce benefits or to refuse to pay benefits that otherwise may be payable in the amount of damages that the covered person has recovered or may recover regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury.

(B)(i) During the pendency of any action or claim that is brought by or on behalf

of a covered person against a third party or its insurance carrier or self-insured entity, any benefits that would otherwise be payable except for the provisions of this subsection shall be paid if payment by or for the third party has not yet been made and the covered person or, if capable, that person's legal representative agrees in writing to pay back properly the benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the third party for the sickness or injury.

(ii) This agreement is to apply whether or not liability for the payments is established or admitted by the third party or whether those payments are itemized.

- (C) Any amounts due the plan to repay benefits may be deducted from other benefits payable by the plan after payments by or for the third party are made.
- (4) Benefits due from the plan may be reduced or refused as an offset against any amount otherwise recoverable under this section.

23-79-511. Confidentiality.

- (a)(1) All steps necessary under state and federal law to protect confidentiality of applicants and covered persons shall be undertaken by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool to prevent the identification of individual records of covered persons under the plan, rejected by the plan, or who may become ineligible for further participation in the plan.
- (2) Procedures shall be written by the board to assure the confidentiality records of persons covered under, rejected by, or who became ineligible for further participation in the plan when gathering and submitting data to the board or any other entity.
- (b) Any information submitted to the board by hospitals or any other provider pursuant to this subchapter from which the identity of a particular individual can be determined shall be privileged and confidential and shall not be disclosed in any manner. The foregoing includes, but shall not be limited to, disclosure, inspection, or copying under § 25-19-101 et seq.

23-79-512. Collective action.

Neither the participation in the plan as insurers, the establishment of rates, forms, or procedures nor any other joint or collective action required by this subchapter shall be the basis of any legal action, criminal or civil liability, or penalty against the plan or any insurer.

23-79-513. Unfair referral to plan.

It shall constitute an unfair trade practice for the purposes of § 23-66-201 et seq. for an insurer, agent, broker, or third-party administrator to refer an individual to the Arkansas Comprehensive Health Insurance Pool, or arrange for an individual to apply to the pool, for the purpose of separating that individual from group health insurance coverage provided in connection with any group health insurance coverage.

Subchapter 6.

Coverage for Diabetes Treatment.

23-79-601. Definitions.

As used in this subchapter:

- (1) "Diabetes self-management training" means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association;
- (2) "Health care insurer" means any insurance company, fraternal benefit society, hospital and medical services corporation, or health maintenance organization issuing or delivering a health insurance policy subject to any of the following laws:
 - (A) The Arkansas Insurance Code, § 23-60-101 et seq.;
 - (B) Section 23-74-101 et seq. relating to fraternal benefit societies;
 - (C) Section 23-75-101 et seq. pertaining to hospital medical service corporations;
 - (D) Section 23-76-101 et seq. pertaining to health maintenance organizations; and
 - (E) Any successor law of the foregoing; and
- (3) "Health insurance policy" means a group insurance policy, contract, or plan or an individual policy, contract, or plan which provides medical coverage on an expense incurred, service, or prepaid risk-sharing basis. The term includes, but is not limited to, a policy, contract, or plan issued by an entity subject to any the following laws:
 - (A) The Arkansas Insurance Code, § 23-60-101 et seq.;
 - (B) Section 23-74-101 et seq. relating to fraternal benefit societies;
 - (C) Section 23-75-101 et seq. pertaining to hospital medical service corporations;
 - (D) Section 23-76-101 et seq. pertaining to health maintenance organizations; and
 - (E) Any successor law of the foregoing.

23-79-602. Diabetes self-management training - Licensed providers - Prescription by physician.

- (a) Every health insurance policy shall include coverage for one (1) per lifetime training program per insured for diabetes self-management training when medically necessary as determined by a physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training.
- (b) Every health care insurer shall offer, in addition to the one (1) lifetime training program provided in subsection (a) of this section, additional diabetes self-

management training in the event that a physician prescribes additional diabetes self-management training and it is medically necessary because of a significant change in the insured's symptoms or conditions.

- (c) A licensed health care professional shall only provide diabetes self-management training within his or her scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his or her licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.
- (d) Diabetes self-management training shall be provided only upon prescription by a physician licensed under § 17-95-201 et seq.
- (e) Nothing in this subchapter shall be construed to prohibit health care insurers from selectively negotiating contracts with qualified providers of diabetes self-management training programs.

23-79-603. Requirements.

- (a) Every health insurance policy shall include medical coverage for medically necessary equipment, supplies, and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a physician licensed under § 17-95-201 et seq.
- (b) The coverage required by this section shall be consistent with that established for other services covered by a given health insurance policy in regard to any of the following:
 - (1) Deductibles, coinsurance, other patient cost-sharing amounts or out-of-pocket limits; or
 - (2) Prior authorization or other utilization review requirements or processes.

23-79-604. Exclusions.

This subchapter shall not be construed as prohibiting a health insurance policy from excluding from coverage diabetes self-management training or equipment or supplies and related services for the treatment of Type I, Type II, or gestational diabetes when the training, equipment, supplies, and services are not medically necessary, provided that the medical necessity determination is made in accordance with generally accepted standards of the medical profession and other applicable laws and regulations.

23-79-605. Regulations.

The State Insurance Department shall develop and promulgate regulations to implement the provisions of this subchapter.

23-79-606. Applicability - Delivery within state.

- (a) This subchapter shall apply to any health insurance policy that is delivered, issued for delivery, renewed, extended, or modified in this state on or after August 1, 1997.
- (b) If a health insurance policy provides coverage or benefits to an Arkansas resident, the policy shall be deemed to be delivered in this state within the meaning of this

subchapter, regardless of whether the health care insurer or other entity that provides the coverage is located within or outside of Arkansas.

23-79-607. Applicability - Exceptions.

This subchapter shall not apply to:

- (1) Long-term care plans;
- (2) Disability income plans;
- (3) Short-term nonrenewable individual health insurance policies that expire after six (6) months;
- (4) Medical payments under homeowner or automobile insurance policies; and
- (5) Workers' compensation insurance.

**Subchapter 7.
Tax Credits for Medically Necessary Foods.**

23-79-701. Definitions.

As used in this subchapter:

- (1) "Health care services" means any services included in the furnishing to any individual of medical 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;
- (2) "Health plan" means any group, blanket, or individual accident and health insurance policy, contract, or plan issued in this state by an insurance company, hospital medical service corporation, or health maintenance organization, provided that nothing in this subchapter shall apply to accident only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies;
- (3) "Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry;
- (4) "Low protein modified food product" means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease;
- (5) "Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician; and
- (6) "Provider" means any person who is licensed in this state to furnish health care services as a health professional.

23-79-702. Tax credit for medically necessary medical foods and low protein modified food products.

- (a) A credit of up to two thousand four hundred dollars (\$2,400) per year per child shall

be allowed to individuals or to families with a dependent child or children with phenylketonuria against the income tax imposed by the Arkansas Income Tax Act of 1929, as amended, § 26-51-101 et seq., for expenses for the purchase of medically necessary medical foods and low protein modified food products.

- (b) The credit allowed in this section shall be effective for taxable years beginning January 1, 1999.
- (c) To the extent that the credit fully available under this subchapter is not fully utilized in this first year, it may be carried forward for an additional two (2) years. Any credit remaining thereafter shall expire.

23-79-703. Health insurance coverage for medically necessary foods.

- (a) All health plans issued, delivered, amended, or modified on or after January 1, 2000, shall provide the minimum benefits set out in subsection (b) of this section for medical foods and low protein modified food products for the treatment of a covered person inflicted with phenylketonuria if:
 - (1) The medical food or low protein modified food products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria;
 - (2) The products are administered under the direction of a physician licensed under § 17-95-401 et seq.; and
 - (3) The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the two thousand four hundred dollars (\$2,400) per year per person income tax credit allowed under § 23-79-702.
- (b)(1) Every health insurance policy, contract, certificate, or health care plan issued in this state by an insurance company, hospital medical service corporation, or health maintenance organization, other than coverage limited to expenses from accident only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies, whether an individual or group policy, contract, certificate, or health care plan, which covers the insured and members of the insured's family, shall provide coverage for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a physician for the therapeutic treatment of phenylketonuria.
 - (2) This benefit may be subject to a deductible, copayments, coinsurance, or other patient cost-sharing amounts required by the health plan.
- (c) If the cost of the medical food or low protein modified food products for an individual or a family with a dependent child or children exceeds the two thousand four hundred dollars (\$2,400) per year per child income tax credit allowed under § 23-79-702 and the individual or a family with a dependent child or children has been denied accident and health insurance or coverage for phenylketonuria or cannot afford insurance coverage for phenylketonuria, the Department of Health shall reimburse the provider up to one thousand dollars (\$1,000) per individual from any funds appropriated therefor for the required health care service, including screening, diagnostic, and treatment services.

Subchapter 8.

Arkansas Health Insurance Consumer Choice Act.

23-79-801. Title.

This subchapter shall be known and cited as the "Arkansas Health Insurance Consumer Choice Act".

23-79-802. Definitions.

For purposes of this subchapter:

- (1) "Health benefits plan" means any individual, blanket, or group plan, policy, or contract for health care services, issued or delivered by a health care insurer, health maintenance organization, or hospital and medical service corporation, excluding plans, policies, or contracts providing health care benefits or health care services pursuant to Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., the Public Employee Workers' Compensation Act, § 21-5-601 et seq., and the no-fault medical and hospital benefit requirements under § 23-89-202; and
- (2)(A) "State-mandated health benefits" means coverages for health care services or benefits required by state law or state regulations, requiring the reimbursement or utilization related to a specific health illness, injury, or condition of the covered person or inclusion of a specific category of licensed health care practitioner to be provided to the covered person in a health benefits plan for a health-related condition of a covered person. Provided that for the purposes of the options provided by this subchapter, state-mandated health benefits which may be excluded, in whole or in part, shall not include any health care services or benefits which were mandated by Act 34 of 1971.
- (B) "State-mandated health benefits" does not mean standard provisions or rights required to be present in a health benefit plan pursuant to state law or regulations unrelated to a specific health illness, injury, or condition of the insured, including, but not limited to, those related to continuation of benefits in § 23-86-114, or entitlement to a conversion policy under § 23-86-115.

23-79-803. Requirements relating to offering a health benefits plan not subject to state-mandated health benefits.

- (a) Every group accident and health insurer, hospital and medical service corporation, or health maintenance organization transacting health or accident and health insurance in this state may offer, as an option, a group health benefits plan which, either in whole or in part, does not provide state-mandated health benefits on group health benefits plans under state law.
- (b) Every accident and health insurer transacting individual major medical insurance in this state may offer, as an option, an individual health benefits plan which, either in whole or in part, does not provide state-mandated health benefits on individual health benefit plans under state law.
- (c) In each sale of health policies or health contracts in which the proposed insured has selected a health benefits plan which, either in whole or in part, does not provide

state-mandated health benefits, the accident and health insurer, hospital and medical service corporation, or health maintenance organization shall:

- (1) Provide to the proposed insured written notice as required in subsection (d) of this section; and
 - (2)(A) Obtain from the proposed insured a rejection in writing that the insured or eligible employee of a group policy has rejected a health benefits plan providing state-mandated health benefits.
 - (B) The signed rejection shall include a listing of the standard provisions and state-mandated health benefits rejected by the insured or eligible employee.
- (d) The written notice required in subsection (c) of this section shall state in the written application or enrollment form for the health benefits plan the following language in bold type:

"You have the option to select an alternative health insurance policy or health plan which is not subject to all of the state mandated health benefits normally required in insurance policies or contracts in Arkansas. Some examples of state mandated health benefits which may be rejected by you include maternity and newborn coverage, in-vitro fertilization, diabetes and pediatric preventative care. Please consult your agent as to which state health benefits are excluded in this policy. This alternative health insurance policy or contract may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits coverages than those normally imposed on health insurance policies in Arkansas. If you select this option, please consult with your insurance agent to discover the degree to which the alternative health insurance policy or contract does not provide health and medical benefits equal to those policies subject to state mandated health benefits. If you are eligible for a health insurance policy, your insurance agent may offer you an alternative health insurance policy or health plan not fully subject to state mandated benefits."

- (e) Failure to provide the written notice or rejection as required in this section shall result in the proposed insured, enrollee, or certificate holder selecting a health benefits plan subject to all applicable state-mandated health benefits and services.

History. Acts 2001, No. 924, § 3.

23-79-804. Report.

- (a) The Insurance Commissioner shall issue a report by June 31 and December 31 of each year to the Senate Insurance and Commerce Interim Committee and the House Insurance and Commerce Interim Committee.
- (b) The report shall include the number of policies written in the State of Arkansas with the limited mandate option and the number of policies written in the State of Arkansas with the full mandate option.
- (c) Every health insurer licensed to conduct business in this state shall provide to the commissioner any information requested by the commissioner in order to issue its report to the committees.

23-79-805. Regulations.

The Insurance Commissioner may promulgate regulations necessary to implement the provisions of this subchapter.

Subchapter 9.
Arkansas Advisory Commission on Mandated Health Insurance Benefits.

23-79-901. Purpose.

It is the intent of the General Assembly to encourage health care cost containment while preserving the quality of care offered to citizens of this state. The General Assembly finds that there is an increasing number of proposals which mandate that certain health insurance benefits be provided by insurers as components of individual and group accident and health policies.

23-79-902. Commission established - Members - Meetings.

- (a) The Arkansas Advisory Commission on Mandated Health Insurance Benefits is established to advise the Governor and the General Assembly on the social, medical, and financial impact of current and proposed mandated benefits and providers.
- (b) The commission shall be composed of fourteen (14) members as follows:
 - (1) Five (5) members shall be appointed by the Governor as follows:
 - (A) One (1) member who is a physician;
 - (B) One (1) member who is a representative of the State Insurance Department;
 - (C) One (1) member with individual health insurance; and
 - (D) Two (2) members of the general public;
 - (2) Five (5) members shall be appointed by the President Pro Tempore of the Senate as follows:
 - (A) One (1) member who is a representative of a general acute care hospital;
 - (B) One (1) member who is a representative of a major industry;
 - (C) One (1) member who is a representative of the accident and health insurance industry;
 - (D) One (1) member who is a dentist; and
 - (E) One (1) member who is a representative of organized labor; and
 - (3) Four (4) members shall be appointed by the Speaker of the House of Representatives as follows:
 - (A) One (1) member who is a representative of a small business;
 - (B) One (1) member who is a licensed accident and health insurance agent;
 - (C) One (1) member who is a representative of the accident and health insurance industry; and
 - (D) One (1) member who is a licensed chiropractor.
- (c)(1) All members shall be appointed for terms of four (4) years each, except for the initial term provided for in subdivision (c)(3) of this section.
- (2) Appointments to fill vacancies shall be made for the remainder of an unexpired

term only.

- (3) The initial terms shall be staggered and shall begin September 1, 2001, with seven (7) members serving an initial term of two (2) years and the seven (7) remaining members serving an initial term of four (4) years. The initial terms shall be determined by lot.
- (4) No person shall be eligible to serve more than two (2) successive terms, or a portion thereof. However, members may be appointed to additional successive terms after a one-year break in service.
- (d) The commission shall meet quarterly or at the request of the Governor. At the first meeting, which shall be held within thirty (30) days after the appointment of the commission, the commission shall select a chair and a vice chair from its membership.

23-79-903. Duties of the commission.

The Arkansas Advisory Commission on Mandated Health Insurance Benefits shall assess the social, medical, and financial impacts of a proposed mandated health insurance service. In assessing a proposed mandated health insurance service and to the extent that information is available, the commission shall consider:

- (1) Social impact, including:
 - (A) The extent to which the service is generally utilized by a significant portion of the population;
 - (B) The extent to which the insurance coverage is already generally available;
 - (C) If coverage is not generally available, the extent to which the lack of coverage results in individuals avoiding necessary health care treatments;
 - (D) If coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship;
 - (E) The level of public demand for the service;
 - (F) The level of public demand for insurance coverage of the service;
 - (G) The level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts; and
 - (H) The extent to which the mandated health insurance service is covered by self-funded employer groups;
- (2) Medical impacts, including:
 - (A) The extent to which the service is generally recognized by the medical community as being effective and efficacious in the treatment of patients;
 - (B) The extent to which the service is generally recognized by the medical community as demonstrated by a review of scientific and peer review literature; and
 - (C) The extent to which the service is generally available and utilized by treating physicians; and
- (3) Financial impacts, including:
 - (A) The extent to which the coverage will increase or decrease the cost of the service;
 - (B) The extent to which the coverage will increase the appropriate use of the

service;

- (C) The extent to which the mandated service will be a substitute for a more expensive service;
- (D) The extent to which the coverage will increase or decrease the administrative expenses of insurers and the premium and administrative expenses of policyholders;
- (E) The impact of this coverage on the total cost of health care; and
- (F) The impact of all mandated health insurance services on employers' ability to purchase health benefits policies meeting their employees' needs.

23-79-904. Contract services - Staff assistance.

- (a) The Arkansas Advisory Commission on Mandated Health Insurance Benefits may contract for actuarial services and other professional services as needed.
- (b) The State Insurance Department and other state agencies, as may be considered appropriate by the commission, shall provide staff assistance to the commission.

23-79-905. Submission of report.

On or before December 31, 2002, and each December 31 immediately preceding a regular session of the General Assembly, the Arkansas Advisory Commission on Mandated Health Insurance Benefits shall submit a report on its findings, including any recommendations, to the Governor and the General Assembly.