

Chapter 86.

Group and Blanket Accident and Health Insurance.

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Subchapter 1.

General Provisions.

23-86-101. Blanket accident and health insurance - Definition.

Blanket accident and health insurance is declared to be that form of accident and health insurance covering groups of persons as enumerated in one (1) of the following subdivisions:

(1) Under a policy or contract issued to any common carrier or to any operator, owner, or lessee of a means of transportation, who or which shall be deemed the policyholder,

covering a group defined as all persons or all persons of a class who may become passengers on the common carrier or such means of transportation;

(2) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering all employees, dependents, or guests, defined by reference to specified hazards incident to the activities or operations of the employer or any class of employees, dependents, or guests similarly defined;

(3) Under a policy or contract issued to a school or other institution of learning, camp, or sponsor thereof or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or campers. Supervisors and employees may be included;

(4) Under a policy or contract issued in the name of any religious, charitable, recreational, educational, or civic organization, which shall be deemed the policyholder, covering participants in activities sponsored by the organization;

(5) Under a policy or contract issued to a sports team or sponsors thereof, which shall be deemed the policyholder, covering members, officials, and supervisors;

(6) Under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group or agency having jurisdiction thereof, which shall be deemed the policyholder, covering all of the members of the fire department or group; or

(7) Under a policy or contract issued to cover any other risk or class of risks that, in the discretion of the Insurance Commissioner, may be properly eligible for blanket accident and health insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

23-86-102. Blanket accident and health insurance - Required provisions.

- (a) Any insurer authorized to write accident and health insurance in this state shall have the power to issue blanket accident and health insurance.
- (b) No blanket policy may be issued or delivered in this state unless a copy of the form shall have been filed in accordance with § 23-79-109.
- (c) Every blanket policy shall contain provisions that in the opinion of the Insurance Commissioner are at least as favorable to the policyholder and the individual insured as the following:
- (1) A provision that the policy and the application shall constitute the entire contract between the parties and that all statements made by the policyholder, in the absence of fraud, shall be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless it is contained in a written application;
- (2)(A) A provision that written notice of sickness or of injury must be given to the insurer within twenty (20) days after the date when such sickness or injury occurred.
- (B) Failure to give notice within the time shall not invalidate or reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;
- (3)(A) A provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss.
- (B) If the forms are not furnished before the expiration of fifteen (15) days after the giving of the notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in

the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made;

(4)(A) A provision that in the case of claim for loss of time for disability, written proof of the loss must be furnished to the insurer within thirty (30) days after the commencement of the period for which the insurer is liable, and the subsequent written proofs of the continuance of the disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of loss.

(B) Failure to furnish proof within the time shall not invalidate or reduce any claim, if it shall be shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible;

(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of the loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of the period will be paid immediately upon receipt of the proof;

(6) A provision that the insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law;

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished; and

(8)(A) In any contract that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of age nineteen (19), and who is chiefly dependent upon the employee for support and maintenance shall not terminate, but coverage shall continue so long as the contract remains in force and so long as the dependent remains in such condition.

(B) At the request and expense of the insurer, proof of the incapacity or dependency must be furnished to the insurer by the policyholder. In no event shall this requirement preclude eligible dependents under Acts 1975, No. 649, § 5, as amended, regardless of age.

(C) If the incapacity or dependency is thereafter removed or terminated, the policyholder shall so notify the insurer.

23-86-103. Blanket accident and health insurance - Application and certificates not required.

An individual application shall not be required from a person covered under a blanket accident and health policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

23-86-104. Blanket accident and health insurance - Payment of benefits.

(a)(1) All benefits under any blanket accident and health policy shall be payable to the person insured, to the designated beneficiaries, or to his or her estate.

(2) However, if the person insured is a minor or mental incompetent, the benefits may be made payable to the parent, guardian, or other person actually supporting the minor or mental incompetent. If the entire cost of the insurance has been borne by the employer, the benefits may be made payable to the employer.

(b)(1) However, the policy may provide that all or any portion of any indemnities provided by the policy on account of hospital, nursing, medical, or surgical services, at the insurer's option, may be paid directly to the hospital or person rendering the services, but the policy may not require that the service be rendered by a particular hospital or person.

(2) Payment so made shall discharge the insurer's obligation with respect to the amount of insurance paid.

23-86-105. [Repealed.]

23-86-106. Group accident and health insurance - Definition.

Group accident and health insurance is declared to be that form of accident and health insurance covering groups of persons as defined in this section, with or without one (1) or more members of their families or one (1) or more of their dependents, or covering one (1) or more members of the families or one (1) or more dependents of the groups of persons, and issued upon the following basis:

(1)(A) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of the employer for the benefit of persons other than the employer.

(B) The term "employees" as used in this subdivision (1) shall be deemed to include the:

(i) Officers, managers, and employees of the employer;

(ii) Individual proprietor or partner, if the employer is an individual proprietor or partnership;

(iii) Officers, managers, and employees of subsidiary or affiliated corporations; and

(iv) Individual proprietors, partners, and employees of individuals and firms, if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise.

(C) The term "employees" as used in this subdivision (1):

(i) May include retired employees; and

(ii) Shall include members of limited liability corporations and members of limited liability partnerships.

(D) A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials.

(E) The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with the trusteeship;

(2)(A) Under a policy issued to an association, including a labor union, that shall have a constitution and bylaws and that has been organized and is maintained in good faith for purposes other than that of obtaining insurance or insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

(B) The term "employees" as used in this subdivision (2) may include retired employees;

(3)(A) Under a policy issued to the trustees of a fund established by two (2) or more employers in the same or related industry or by one (1) or more labor unions or by one (1) or more employers and one (1) or more labor unions or by an association as defined in subdivision (2) of this section, who shall be deemed the policyholder, to insure employees of the employers or members of the unions or of the association, or employees of members of the association, for the benefit of persons other than the employers or the unions or the association.

(B) The term "employees" as used in this subdivision (3) may include:

(i) The officers, managers, and employees of the employer and the individual proprietor or partners, if the employer is an individual proprietor or partnership; and

(ii) Retired employees.

(C) The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any classes of individuals that could be insured under the group life policy; and

(5) Under a policy issued to cover any other substantially similar group that, in the discretion of the Insurance Commissioner, may be subject to the issuance of a group accident and health policy or contract.

23-86-107. Group accident and health insurance - Requires authorized insurer.

(a) All group accident and health insurance placed by an employer on employees who are residents of this state shall be placed by the employer with an insurer authorized to transact insurance in this state.

(b) This section shall not apply to group insurance lawfully placed in an insurer transacting insurance as a surplus line insurer under § 23-65-101 et seq.

23-86-108. Group accident and health insurance - Required provisions.

Each group accident and health insurance policy shall contain in substance the following provisions:

(1) A provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits unless contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the person or his or her beneficiary;

(2)(A) A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member and to whom benefits under the policy are payable.

(B) If dependents are included in the coverage, only one (1) certificate need be issued for each family unit;

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy;

(4)(A) In any contract that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of age nineteen (19) and who is chiefly dependent upon the employee for support and maintenance, shall not terminate but coverage shall continue so long as the coverage of the employee or member remains in force and so long as the dependent remains in such condition.

(B) At the request and expense of the insurer, proof of the incapacity or dependency must be furnished to the insurer by the policyholder, except in no event shall this requirement preclude eligible dependents under Acts 1975, No. 649, § 5, as amended, regardless of age.

(C) If the incapacity or dependency is thereafter removed or terminated, the policyholder shall so notify the insurer;

(5)(A) No policy or contract of group accident and health insurance, including contracts issued by hospital and medical service corporations, that provides coverage for any of the following services when delivered on an inpatient basis shall hereafter be sold, delivered, or issued for delivery or offered for sale in this state unless the identical coverage for such services is provided when delivered on an outpatient basis:

(i) Laboratory and pathological tests;

(ii) X rays;

(iii) Chemotherapy;

(iv) Radiation treatment; and

(v) Renal dialysis.

(B) However, the coverage required by subdivision (5)(A) of this section shall not be required where any policyholder or contract holder shall reject the coverage in writing.

(C) The definition of the services referred to in this subdivision (5) shall be the same as found in § 23-85-133.

(D) All existing group contracts, including existing group contracts issued by hospital and medical service corporations, shall conform to the provisions of this subdivision (5) upon the first anniversary of the issue date, after March 12, 1981;

(6) A provision that:

(A) All benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of written proof of such loss;

(B) Subject to proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which the insurer is liable; and

(C) Any balance remaining unpaid at the termination of that period will be paid immediately upon receipt of due proof; and

(7)(A) Every insurer, hospital or medical service corporation, fraternal benefit society, self-funded health care plan, or health maintenance organization providing replacement coverage, with respect to group accident and health benefits within a period of sixty (60) days from the date of discontinuance of a prior plan, shall immediately cover all employees and dependents:

(i) If each employee or dependent was validly covered under the previous plan at the date of the discontinuance;

(ii) If each employee or dependent is a member of the class of individuals eligible for coverage under the succeeding carrier's plan, regardless of any of the plan's limitations or exclusions relating to "actively at work" or hospital confinement; and

(iii) Only if the group accident and health benefits were provided to a group consisting of more than fifteen (15) members.

(B) The succeeding carrier shall be entitled to deduct from its benefits any benefits payable by the previous carrier pursuant to an extension of benefits provision.

(C) No provision in a succeeding carrier's plan of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's plan shall be applied with respect to those employees and dependents validly insured under the previous carrier's policy on the date of discontinuance, if benefits for the condition would have been payable under the previous carrier's plan.

(D) The provisions of this section shall apply upon the issuance of an insurance policy or health care plan:

(i) To a group whose benefits had previously been self-insured;

(ii) To a self-insurer providing coverage to a group that had been previously covered by an insurer; and

(iii) To a group that had previously been covered by an insurer.

23-86-109. Group accident and health insurance - Optional continuation of benefit provisions.

Any group accident and health policy that contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group may provide for the continuation of the benefit provisions, or any parts thereof, after the death of the person in the insured group.

23-86-110. Group accident and health insurance - Administration of benefits.

(a)(1) All group accident and health carriers including hospital and medical service corporations shall be subject to the "primary" and "secondary" carrier rules and regulations promulgated by the Insurance Commissioner.

(2) The secondary carrier shall administer benefits on a timely basis.

(b) This section shall be applicable to all group contracts of accident and health insurance sold, delivered, or issued for delivery, renewed, or offered for sale in this state,

including those issued by hospital and medical service corporations, except group contracts for employees whose employer pays one hundred percent (100%) of the premiums.

23-86-111. Group accident and health insurance - Payment of benefits where other like insurance exists.

(a)(1) No contract of group accident and health insurance coverage sold, delivered or issued for delivery, renewed, or offered for sale in this state by an insurer, hospital and medical service corporation, or health maintenance organization, directly or indirectly providing indemnity, services, health care services, or cash to an individual as a result of hospitalization, medical or surgical treatment, or dental care, shall contain any provision for the denial or reduction of benefits because of the existence of other like insurance except to the extent that the aggregate benefits with respect to the covered medical expenses incurred under the contract and all other like insurance with other insurers, hospital and medical service corporations, or health maintenance organizations exceed all covered medical expenses incurred.

(2) The term "other like insurance" may include group or blanket accident and health insurance or group coverage provided by health maintenance organizations, hospital and medical service corporations, government insurance plans, except Medicaid, union welfare plans, employer or employee benefit organizations, or workers' compensation insurance or no-fault automobile coverage provided for or required by any statute.

(b)(1) No group accident and health insurance policy providing disability income coverage sold, delivered, or issued for delivery, renewed, or offered for sale in this state shall provide for reduction in the amount of the disability benefits payable to the insured to the extent of and because of the existence of other such coverage unless the policy provides a minimum amount payable, regardless of the reduction, of fifty dollars (\$50.00) per month.

(2) "Other such coverage" for which a reduction may be effected includes:

(A) Governmental programs such as federal social security, the Arkansas Public Employees' Retirement System, the state workers' compensation system, and all other government-sponsored, mandatory plans or programs that provide for disability benefit coverage;

(B) Disability or pension income coverages as established by the Insurance Commissioner through implementing rules and regulations; and

(C) Such other programs, coverages, or permissible reductions as the commissioner may establish through rules and regulations.

(3) The amount of any such reduction shall not be increased with any increase in the level of federal social security benefits payable that becomes effective after a claim commences.

(4) The commissioner may also issue rules and regulations to implement this section and § 23-86-110, including, but not limited to, the nature and timing of proofs of eligibility for federal social security benefits.

(c) This section shall be applicable to all group contracts of accident and health insurance sold, delivered, or issued for delivery, renewed, or offered for sale in this state,

except group contracts for employees whose employer pays one hundred percent (100%) of the premiums.

23-86-112. Group accident and health insurance - Direct payment of hospital or medical services.

(a) Any group accident and health policy, on request by the group policyholder, may provide that all or any portion of any indemnities provided by any policy on account of hospital, nursing, medical, or surgical services may be paid, at the insurer's option, directly to the hospital or person rendering such services, but the policy may not require that the service be rendered by a particular hospital or person.

(b) Payment so made shall discharge the insurer's obligation with respect to the amount of insurance paid.

23-86-113. Minimum benefits for mental illness in group accident and health policies or subscriber's contracts.

(a) Unless refused in writing, every group accident and health policy or group contract of hospital and medical service corporations issued or renewed after July 1, 1983, providing hospitalization or medical benefits to Arkansas residents for conditions arising from mental illness shall provide the following minimum benefits on and after July 1, 1983:

(1) In the case of benefits based upon confinement as an inpatient in a hospital, psychiatric hospital, or outpatient psychiatric center licensed by the Department of Health or a community mental health center certified by the Division of Mental Health Services of the Department of Human Services, the benefits shall be as defined in subsection (b) of this section;

(2)(A) In the case of benefits provided for partial hospitalization in a hospital, psychiatric hospital, or outpatient psychiatric center licensed by the Department of Health or a community mental health center certified by the Division of Mental Health Services of the Department of Human Services as defined in subsection (b) of this section.

(B) For the purpose of this section, "partial hospitalization" means continuous treatment for at least four (4) hours, but not more than sixteen (16) hours in any twenty-four-hour period; and

(3) In the case of outpatient benefits, the benefits shall cover services furnished by:

(A) A hospital, a psychiatric hospital, or an outpatient psychiatric center licensed by the Department of Health;

(B) A physician licensed under the Medical Practices Act, § 17-95-201 et seq.;

(C) A psychologist licensed under § 17-97-201 et seq.; or

(D) A community mental health center or other mental health clinic certified by the Division of Mental Health Services of the Department of Human Services to furnish mental health services as defined in subsection (b) of this section.

(b) The insurer or hospital and medical service corporation may establish a copayment requirement for mental illness benefits paid for inpatient, partial hospitalization, or outpatient care described in subsection (a) of this section, which may or may not differ from the copayment requirements for any other condition or illness, except that

copayment requirements for mental illness shall not exceed a twenty percent (20%) copayment requirement.

(c)(1) For accident and health insurance sold to employers of fifty (50) or fewer employees, the insurer or hospital and medical service corporation shall not impose limits on benefits under subsection (a) of this section with regard to deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization which differ from benefits for any other condition or illness, provided such insurer or hospital and medical service corporation may impose an annual maximum benefit payable, which shall not be less than seven thousand five hundred dollars (\$7,500) per calendar year.

(2) For accident and health insurance sold to employers of fifty-one (51) or more employees, the insurer or hospital and medical service corporation shall not impose limits on benefits under subsection (a) of this section with regard to deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization which differ from benefits for any other condition or illness, provided the insurer or hospital and medical service corporation may impose an annual maximum of eight (8) inpatient or partial hospitalization days together with forty (40) outpatient visits.

(d) No person shall disclose mental health history, diagnosis, or treatment services information received in an initial application for coverage or subsequent claims for benefits to any person, group, organization, or governmental agency, without written consent of the insured, except for purposes of:

- (1) Obtaining professional review and judgments of quality and appropriateness of treatment rendered;
- (2) Litigation proceedings involving the insured and when ordered by a court;
- (3) Reinsurance, when required;
- (4) Applying over-insurance provisions or for purposes of claiming benefits for services on behalf of the insured; or
- (5) Underwriting applications for insurance coverage.

(e) Nothing in this section shall be construed to prohibit an insurer, hospital and medical service corporations, a health care plan, health maintenance organization, or other person providing accident and health insurance or medical benefits to Arkansas residents from issuing or continuing to issue an accident and health insurance benefit plan, policy, or contract that provides benefits greater than the minimum benefits required to be made available under this section or from issuing any plans, policies, or contracts that provide benefits that are generally more favorable to the insured than those required to be made available under this section.

(f) The requirements of this section with respect to a group or blanket accident and health insurance benefit plan, policy, or subscriber contract shall be satisfied, if the coverage specified is made available to the master policyholder of the plan, policy, or contract.

(g)(1)(A) Every insurer or hospital and medical service corporation that issues a group accident and health insurance policy, contract, or agreement in this state that provides for mental health coverage shall offer coverage for the payment of services rendered by licensed professional counselors.

(B) The offer shall be made either at the time of application for, or upon the first renewal of, the policy, contract, or agreement after April 1, 1995.

(C) If the offer is accepted, the amount paid for services provided by licensed professional counselors shall be subject to the same limitations as set forth in the policy for mental health coverage.

(2) Nothing in this subsection shall be deemed to expand the scope of the practice of licensed professional counselors currently licensed by the Arkansas Board of Examiners in Counseling and possessing the qualifications set forth in § 17-27-301 et seq., or other applicable laws.

23-86-114. Group accident and health insurance - Continuation of coverage beyond termination of employment, change in marital status, etc.

(a) Every group accident and health insurance policy, contract, or certificate providing hospital, surgical, or major medical coverage, other than accident only or specified disease policies, shall contain a provision that any certificate holder, member, or spouse whose coverage under the policy would otherwise terminate due to termination of employment or membership or a change in marital status may continue coverage under the policy for themselves and their eligible dependents as provided in this section.

(b) The continued coverage need not include benefits for dental care, vision services, or prescription drug expenses.

(c)(1) Continuation of coverage shall be available only to individuals who have been insured continuously under the group policy during the three-month period prior to the termination of employment membership or change in marital status.

(2) Continuation of coverage shall not be available to an individual who is eligible for:

(A) Federal Medicare coverage; or

(B)(i) Full coverage under any other group accident and health policy or contract.

(ii) This coverage must provide benefits for all preexisting conditions to be considered full coverage.

(iii) Accordingly, under this subdivision (c)(2), an individual may continue his or her previous group coverage until all preexisting conditions are covered or would be covered under another group policy or contract or until termination pursuant to subsection (f) of this section or pursuant to the applicable provisions of federal law.

(d) An individual who wishes to continue coverage must request continuation in writing not later than ten (10) days after the termination of employment or membership or the change in marital status.

(e) An individual who requests continuation of coverage must pay the premium required by the policyholder on a monthly basis and in advance. Payments shall be made in accordance with the group policy.

(f) Continuation of coverage shall end upon the earliest of the following dates:

(1) One hundred twenty (120) days after continuation of coverage began;

(2) The end of the period for which the individual made a timely contribution;

(3) The contribution due date following the date the individual becomes eligible for Medicare; or

- (4) The date on which the policy is terminated or the group withdraws from the plan. However, if the group policy is replaced, continuation shall continue under the new coverage.
- (g) At the termination of the continued coverage, an individual shall be offered the conversion policy under the group policy.
- (h) Individuals choosing to utilize the conversion privilege under the group policy may do so and thereby waive their right to continuation of coverage.
- (i) This section shall not be applicable to health care plans in which the employer is self-insured.

23-86-115. Group accident and health insurance - Entitlement to conversion policy upon termination of group policy.

(a)(1) Every group policy, contract, or certificate of accident and health insurance delivered or issued for delivery in this state that provides hospital, surgical, or major medical coverage on an expense-incurred basis, other than coverage limited to expenses from accidents or specified diseases, shall provide that an employee, member, or covered dependent whose insurance under the group policy has been terminated for any reason, including the discontinuance of the group policy in its entirety, shall be entitled to have issued to him or her by the insurer a policy of accident and health insurance referred to in this section as a conversion policy.

(2) An employee, member, or dependent shall not be entitled to a conversion policy, if the termination of the group policy, contract, or certificate was a result of his or her failure to pay any required contribution or if the terminated policy is replaced by similar coverage within thirty-one (31) days.

(3) An individual wishing to exercise his or her conversion privilege must apply for the conversion policy in writing not later than thirty (30) days after the termination of the group coverage.

(b)(1) The conversion policy shall provide coverage equal to or greater than the minimum standards established by the Insurance Commissioner. All conversion policies shall contain a wording in bold print that "the benefits in this policy do not necessarily equal or match those benefits provided in your previous group policy".

(2) The conversion policy shall not exclude coverage for pregnancy or other illness or injury on the grounds of a preexisting condition, provided that the combination of time served under the group and the conversion policy equals or exceeds any waiting periods under the group policy or contract. Moreover, the conversion policy shall include benefits for maternity coverage for any pregnancies in existence at the time of the conversion.

(c)(1) The insurer shall not be required to offer the conversion policy to any individual who is eligible for:

(A) Federal Medicare coverage; or

(B) Full coverage under any other group accident and health policy or contract. This coverage must provide benefits for all preexisting conditions to be considered full coverage.

(2) Accordingly, under this subsection, an individual may convert to a conversion policy and remain covered by that policy until all preexisting conditions are covered or would be covered under another group policy or contract.

- (d) This section shall not be applicable to self-insured plans.
- (e)(1)(A) The initial premium for the conversion policy for the first twelve (12) months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks for the age and class of risk of each person to be covered under the conversion policy and for the type and amount of insurance provided.
- (B) The experience under conversion policies shall not be an acceptable basis for establishing rates for conversion policies.
- (2) For purposes of subdivision (e)(1) of this section:
- (A) The phrase "premium rates applicable to individually underwritten standard risks" means the premium charged to individuals who qualify for coverage without modification, determined from a rate table based on aggregate individually underwritten policy experience;
- (B) "Aggregate individually underwritten policy experience" means the policy experience is drawn from a mature combination of newly selected insureds and insureds for whom selection effects no longer exist; and
- (C) "Class" means any actuarially determined characteristic, except health status or individual claims experience.
- (3) If an insurer experiences incurred losses that exceed earned premiums for a period of two (2) successive years on conversion policies that have been in force for at least one (1) year, the insurer may file with the commissioner amended renewal rates for the subsequent year, which will produce a loss ratio of not less than one hundred percent (100%).
- (4)(A) Even though a renewal premium is established in accordance with subdivision (e)(3) of this section, a holder of the conversion policy shall not be required to pay the full renewal premium until the beginning of the policy's fourth year.
- (B) The premium for the second policy year shall be the initial premium plus thirty-three and one-third percent ($33\frac{1}{3}\%$) of the difference between the initial premium and the renewal premium in effect on the policy's first anniversary date.
- (C) The premium for the third policy year shall be the initial premium plus sixty-six and two-thirds percent ($66\frac{2}{3}\%$) of the difference between the initial premium and the renewal premium in effect on the policy's second anniversary date.
- (D) The premium for the fourth year shall be one hundred percent (100%) of the renewal premium in effect on the policy's third anniversary date.
- (5) This subsection shall be applicable to any conversion policy issued after March 22, 1995.

23-86-116. Continuation of benefits upon termination of policy.

- (a) Every group accident and health insurance policy, contract, or certificate that provides coverage for hospital or medical services or expenses shall provide that the insurer shall continue its obligation for benefits under the policy or contract for any person insured under the policy or contract who is hospitalized on the date of termination, if the policy or contract is terminated and replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan.

(b) Any payment required under this section is subject to all terms, limitations, and conditions of the policy or contract except those relating to termination of benefits. Any obligation by an insurer under this section continues until the hospital confinement ends or hospital benefits under the policy or contract are exhausted, whichever is earlier.

23-86-117. Standard claim form required.

(a) All accident and health insurers transacting business in this state shall use Form HCFA 1500 and Form UB-92/HCFA 1450 or in the claim format required by the Health Insurance Portability and Accountability Act of 1996 as the standard claim forms until and unless the Insurance Commissioner prescribes otherwise.

(b) Pursuant to the applicable provisions of the Arkansas Insurance Code, § 23-60-101 et seq., the commissioner may suspend or revoke the certificate of authority of any insurance company that refuses to use and accept the standard claim form required by this section, or the commissioner may utilize any remedy provided in § 23-66-210.

23-86-118. In vitro fertilization coverage required.

(a) All accident and health insurance companies doing business in this state shall include, as a covered expense, in vitro fertilization.

(b) The Insurance Commissioner, pursuant to the applicable provisions of the Arkansas Insurance Code, § 23-60-101 et seq., may suspend or revoke the certificate of authority of any insurance company failing to comply with the provisions of this section.

(c) After conducting appropriate studies and public hearings, the commissioner shall establish minimum and maximum levels of coverage to be provided by the accident and health insurance companies.

(d) Coverage required under this section shall include services performed at a medical facility licensed or certified by the Department of Health, those performed at a facility certified by the department that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics, or those performed at a facility certified by the department that meets the American Fertility Society minimal standards for programs of in vitro fertilization.

23-86-119. Disclosure to policyholders.

(a) Any insurer issuing or delivering group accident and health insurance policies in this state must provide to a policyholder with more than ninety-nine (99) insured employees under a comprehensive health insurance policy the following information for the most recent twelve-month period or for the entire period of coverage, whichever is shorter:

- (1) Claims incurred by month;
- (2) Premiums paid by month;
- (3) Number of insureds to include dependents by month; and
- (4) Claims exceeding ten thousand dollars (\$10,000) on any individual with diagnosis during the same period.

(b) This section does not require the insurer to disclose any information that is required by law to be confidential.

23-86-120. Hospice care coverage for terminally ill patients.

(a)(1) Every accident and health insurance company, hospital service corporation, health maintenance organization, or other health insurance provider in the State of Arkansas shall offer to each master group contract holder, coverage for hospice facilities and hospice programs as defined under § 20-7-117.

(2)(A) The offer of these benefits shall be subject to the right of the policy or contract holder to reject the coverage.

(B) The rejection by the policy or contract holder shall be in writing.

(b) The insurance coverage required in subsection (a) of this section shall provide terminally ill patients with coverage for prognosis and treatment of at least the rates of reimbursement as are provided for hospice care under Medicare, the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as in effect January 1, 1999.

(c) This section does not apply to contracts or policies providing disability income insurance, specified disease insurance, hospital indemnity insurance, long-term care insurance, short-term limited duration insurance, accident only insurance, medicare supplement insurance, or all other supplemental insurance.

Subchapter 2.

Small-Employer Health Insurance.

23-86-201. Purpose.

The intent of this subchapter is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, and to improve the efficiency and fairness of the small group health insurance marketplace.

23-86-202. Definitions.

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individuals acceptable to the Insurance Commissioner that a small employer carrier is in compliance with the provisions of § 23-86-204 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans;

(2) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

(3) "Carrier" means health insurance issuer, i.e., an insurance company, insurance service, or insurance organization, including a health maintenance organization that is licensed to engage in the business of insurance in a state and that is subject to Arkansas law that regulates insurance, but the term does not include a group health plan;

(4) "Case characteristics" means demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, that are considered by the carrier in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purposes of this subchapter;

(5) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier;

(A) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(i) Are marketed and sold through individuals and organizations that are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;

(ii) Have been acquired from another small employer carrier as a distinct grouping of plans;

(iii) Are provided through an association with membership of not less than two (2) or more small employers that has been formed for purposes other than obtaining insurance; or

(iv) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in § 23-86-204(a)(1)(A);

(B) A small employer carrier may establish no more than two (2) additional groupings under each of subdivisions (5)(A)(i), (ii), (iii), and (iv) of this section on the basis of underwriting criteria that are expected to produce substantial variation in the health care costs;

(C) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace;

(6) "Commissioner" means the Insurance Commissioner;

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

(8)(A) "Health benefit plan" or "plan" means health insurance coverage, i.e., benefits consisting of medical care, provided directly through insurance or reimbursement or otherwise, and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer;

(B) "Health benefit plan" does not include accident-only, credit, dental, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance;

(9) "Index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(10) "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

(11) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier;

(12) "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no fewer than two (2) nor more than twenty-five (25) eligible employees. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation shall be considered one (1) employer; and

(13) "Small employer carrier" means health insurance issuer as defined in subdivision (3) of this section.

23-86-203. Health insurance plans subject to this subchapter.

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter apply to any health benefit plan that provided coverage to two (2) or more employees of a small employer.

(b) The provisions of this subchapter shall not apply to individual health insurance policies that are subject to policy form and premium rate approval as provided in § 23-79-109 and § 23-85-101 et seq.

23-86-204. Restrictions relating to premium rates.

(a) Premium rates for health benefit plans subject to this subchapter shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%). This subdivision shall not apply to a class of business if all of the following apply:

(A) The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status;

(B) The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business; and

(C) The class of business is currently available for purchase;

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate;

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(B) An adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status, or

duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

(C) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business; and

(4) In the case of health benefit plans issued prior to January 1, 1992, a premium rate for a rating period may exceed the ranges described in subsection (a)(1) or (2) of this section for a period of five (5) years following January 1, 1992. In such case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(B) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(b) Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

(c)(1) A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business.

(2) A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

23-86-205, 23-86-206. [Repealed.]

23-86-207. Maintenance of records.

(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file each March 1 with the Insurance Commissioner an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of such certification shall be retained by the carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (a) of this section available to the commissioner upon request. The information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

23-86-208. Discretion of the commissioner.

The Insurance Commissioner may suspend all or any part of § 23-86-204 as to the premium rates applicable to one (1) or more small employers for one (1) or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

23-86-209. Effective date.

(a) The provisions of this subchapter shall apply to each health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state after July 1, 1997.

(b) For purposes of this section, the date a plan is continued is the first rating period which commences after July 1, 1997.

Subchapter 3.

Arkansas Health Insurance Portability and Accountability Act of 1997.

23-86-301. Title.

This subchapter may be cited as the "Arkansas Health Insurance Portability and Accountability Act of 1997".

23-86-302. Effective date - Limitation of actions - Applicability.

(a) In General. Except as provided in this section, this subchapter and the amendments made by this section shall apply with respect to group health plans for plan years beginning after June 30, 1997.

(b) Determination of Creditable Coverage.

(1) Period of Coverage - In General. Subject to subdivision (b)(2)(A) of this subsection, no period before July 1, 1996, shall be taken into account in determining creditable coverage.

(2) Certifications.

(A) In General. Subject to subdivisions (b)(2)(B) and (C) of this section, § 23-86-304(e) shall apply to events occurring after June 30, 1996.

(B) No Certification Required to be Provided Before June 1, 1997. In no case is a certification required to be provided under § 23-86-304(e) before June 1, 1997.

(C) Certification Only on Written Request for Events Occurring Before October 1, 1996. In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under § 23-86-304(e) unless an individual with respect to whom the certification is otherwise required to be made requests such certification in writing.

(3) Transitional Rule. In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996:

(A) The individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

(B) A group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting or not crediting such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements of this section.

(c) Limitation on Actions. No enforcement action shall be taken pursuant to this section against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by this section before January 1, 1998, or, if later, the date of issuance of regulations by the Secretary of Labor, if the plan or issuer has sought to comply in good faith with such requirements.

(d) Applicability.

(1) The provisions of this subchapter shall be applicable to all accident and health insurers, health maintenance organizations, hospital and medical service corporations, and fraternal benefit societies that are licensed and authorized by the Insurance Commissioner to transact business in the State of Arkansas.

(2) The provisions of this subchapter shall be applicable to all licensed or state-regulated multiple employer welfare arrangements, licensed or state-regulated health benefit plans, licensed or state-regulated multiple employer trusts, or other licensed or state-regulated persons providing a plan of group health insurance coverage in this state.

23-86-303. Definitions.

For purposes of this subchapter, the following terms are hereby defined:

(1) "Affiliation period" means a period that, under the terms of the coverage offered by the health maintenance organization, must expire before the coverage becomes effective;

(2) "Bona fide association" means, with respect to health insurance coverage offered in Arkansas, an association that:

(A) Has been actively in existence for at least five (5) years;

(B) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) Does not condition membership in the association on any health status-related factor relating to an individual including an employee of an employer or a dependent of an employee;

(D) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member;

(E) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) Meets the additional requirements that may be imposed under Arkansas law;

(3) "Church plan" has the meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA);

(4) "COBRA continuation provision" means any of the following:

- (A) Part 6 of Subtitle B of Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA), other than section 609 of the act;
- (B) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of the section insofar as it relates to pediatric vaccines;
- (C) Title XXII of the Public Health Service Act;
- (5) "Commissioner" and "Insurance Commissioner" mean the Insurance Commissioner for the State of Arkansas;
- (6) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:
 - (A) A group health plan;
 - (B) Health insurance coverage;
 - (C) Part A or Part B of Title XVIII of the Social Security Act;
 - (D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
 - (E) Chapter 55 of Title 10, United States Code;
 - (F) A medical care program of the Indian Health Service or of a tribal organization;
 - (G) A state health benefits risk pool;
 - (H) A health plan offered under Chapter 89 of Title 5, United States Code;
 - (I) A public health plan as defined in regulations;
 - (J) A health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. § 2504(e). The term does not include coverage consisting solely of coverage of excepted benefits as defined in § 23-86-310 of this subchapter;
- (7) "Department" means the State Insurance Department unless the context requires otherwise;
- (8) "Eligible individual" means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small group market, such an individual in relation to the employer as shall be determined:
 - (A) In accordance with the terms of the plan;
 - (B) As provided by the issuer under rules of the issuer that are uniformly applicable in Arkansas to small employers in the small group market; and
 - (C) In accordance with all applicable Arkansas law governing the issuer and the market;
- (9)(A) "Employee" has the meaning given the term under § 3(6) of the Employee Retirement Income Security Act of 1974.
 - (B) To the extent not in conflict with the Employee Retirement Income Security Act of 1974, the term "employee" also means a person who is employed by an employer for thirty (30) or more hours a week and includes an employee who is employed by a client of a professional employer organization for thirty (30) or more hours a week under a professional employer organization arrangement as governed under § 23-92-401 et seq.;
- (10) "Employer" has the meaning given the term under section 3(5) of the Employee Retirement Income Security Act of 1974 (ERISA), except that the term shall include only employers of two (2) or more employees;
- (11) "Employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries;

- (12) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of coverage of the individual in the plan or, if earlier, the first day of the waiting period for the coverage;
- (13) "Federal governmental plan" means a governmental plan established or maintained for its employees by the United States Government or by any agency or instrumentality of the government;
- (14) "Governmental plan" has the meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) and any federal governmental plan;
- (15) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with the plan;
- (16) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care, as defined in this section and including items and services paid for as medical care, to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise;
- (17) "Group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer;
- (18) "Health insurance coverage" means benefits consisting of medical care, provided directly, through insurance or reimbursement or otherwise and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer;
- (19) "Health insurance issuer" means an insurance company, insurance service, or insurance organization including a health maintenance organization as defined in this section that is licensed to engage in the business of insurance in a state and that is subject to Arkansas law that regulates insurance. The term does not include a group health plan;
- (20) "Health maintenance organization" means:
- (A) A federally qualified health maintenance organization as defined in section 1301(a) of the Public Health Service Act, 42 U.S.C. § 300e(a);
 - (B) An organization recognized under state law as a health maintenance organization; or
 - (C) A similar organization regulated under state law for solvency in the same manner and to the same extent as a health maintenance organization;
- (21) "Health status-related factor" means any of the factors described in § 23-86-306(a)(1);
- (22) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan;
- (23) "Large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one (51) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;
- (24) "Large-group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a large employer;

- (25) "Late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:
- (A) The first period in which the individual is eligible to enroll under the plan; or
 - (B) A special enrollment period under § 23-86-304(f);
- (26) "Medical care" means amounts paid for or services provided for:
- (A) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
 - (B) Amounts paid for transportation primarily for and essential to medical care referred to in subdivision (26)(A) of this section; and
 - (C) Amounts paid for insurance covering medical care referred to in subdivisions (26)(A) and (B) of this section;
- (27) "Network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer;
- (28) "Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan;
- (29) "Participant" has the meaning given the term under section 3(7) of the Employee Retirement Income Security Act of 1974 (ERISA);
- (30) "Placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by the person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation;
- (31) "Plan sponsor" has the meaning given the term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (ERISA);
- (32) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date;
- (33) "Regulations" means rules and regulations promulgated by the Insurance Commissioner unless the context requires otherwise;
- (34) "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;
- (35) "Small-group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a small employer;
- (36) "State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands;
- (37) "State law" includes all laws, decisions, rules, regulations, or other state action having the effect of law, of any state. A law of the United States applicable only to the District of Columbia shall be treated as a state law rather than a law of the United States; and

(38) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

23-86-304. Increased portability through limitation on preexisting conditions exclusions.

(a) Limitation on Preexisting Condition Exclusion Period - Crediting for Periods of Previous Coverage. Subject to subsection (d) of this section, a group health plan and a health insurance issuer offering group health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(2) The exclusion extends for a period of not more than twelve (12) months, or eighteen (18) months in the case of a late enrollee, after the enrollment date; and

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, as defined in subdivision (c)(1) of this section, applicable to the participant or beneficiary as of the enrollment date.

(b) Treatment of Genetic Information. Genetic information shall not be treated as a condition described in subdivision (a)(1) of this section in the absence of a diagnosis of the condition related to such information.

(c) Creditable coverage - Rules Relating to Crediting Previous Coverage.

(1) Not Counting Periods Before Significant Breaks in Coverage.

(A) In General. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting Period Not Treated as a Break in Coverage. For purposes of subdivision (c)(1)(A) and subdivision (d)(4) of this section, 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 as defined in § 23-86-303(1) shall not be taken into account in determining the continuous period under subdivision (c)(1)(A) of this section.

(2) Method of Crediting Coverage.

(A) Standard Method. Except as otherwise provided under subdivision (c)(2)(B) of this section, for purposes of applying subdivision (a)(3) of this section, a group health plan and a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) Election of Alternative Method. (i) A group health plan or a health insurance issuer offering group health insurance coverage may elect to apply subdivision (a)(3) of this section based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subdivision (c)(2)(A) of this section.

(ii) The election shall be made on a uniform basis for all participants and beneficiaries.

(iii) Under the election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(C) Plan Notice. In the case of an election with respect to a group health plan under subdivision (c)(2)(B) of this section, whether or not health insurance coverage is provided in connection with such plan, the plan shall:

(i) Prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election; and

(ii) Include in such statements a description of the effect of this election.

(D) Issuer Notice. In the case of an election under subdivision (c)(2)(B) of this section with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer:

(i) Shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election; and

(ii) Shall include in such statements a description of the effect of such election.

(3) Establishment of Period. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) of this section or in such other manner as may be specified in regulations.

(d) Exceptions.

(1) Exclusion Not Applicable to Certain Newborns. Subject to subdivision (d)(4) of this section, a group health plan and a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion Not Applicable to Certain Adopted Children. Subject to subdivision (d)(4) of this section, a group health plan and a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The preceding sentence in this subdivision (d)(2) shall not apply to coverage before the date of the adoption or placement for adoption.

(3) Exclusion Not Applicable to Pregnancy. A group health plan and health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if Break in Coverage. Subdivisions (d)(1) and (2) of this section shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage.

(1) Requirement for Certification of Period of Creditable Coverage.

(A) In General. A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subdivision (e)(1)(B) of this section:

- (i) At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;
- (ii) In the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision; and
- (iii)(a) At the request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subdivisions (e)(1)(A)(i) or (e)(1)(A)(ii) of this section, whichever is later.

(b) The certification under subdivision (e)(1)(A)(i) of this section may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification. The certification described in subdivision (e)(1)(A) of this section is a written certification of:

- (i) The period of creditable coverage of the individual under such plan and the coverage, if any, under such COBRA continuation provision; and
- (ii) The waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under such plan.

(C) Issuer Compliance. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this section if the health insurance issuer offering the coverage provides for such certification in accordance with this section.

(2) Disclosure of Information on Previous Benefits. In the case of an election described in subdivision (c)(2)(B) of this section by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subdivision (e)(1) of this section:

(A) Upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and

(B) Such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(f) Special Enrollment Periods.

(1) Individuals Losing Other Coverage. A group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer if applicable required such a statement at such time and provided the employee with notice of such requirement and the consequences of such requirement at such time;

(C) The employee's or dependent's coverage described in subdivision (f)(1)(A) of this section:

- (i) Was under a COBRA continuation provision and the coverage under such provision was exhausted; or
- (ii) Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage including loss as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions toward such coverage were terminated; and

(D) Under the terms of the plan, the employee requests such enrollment not later than thirty (30) days after the date of exhaustion of coverage described in subdivision (f)(1)(C)(i) of this section or termination of coverage or employer contribution described in subdivision (f)(1)(C)(ii) of this section.

(2) For Dependent Beneficiaries.

(A) In General. If:

- (i) A group health plan makes coverage available with respect to a dependent of an individual;
- (ii) The individual is a participant under the plan or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for that individual's failure to enroll during a previous enrollment period; and
- (iii) A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, then the enrollment period described in subdivision (f)(2)(B) of this section shall be provided, during which the person, or, if not otherwise enrolled, the individual, may be enrolled under the plan as a dependent of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

(B) Dependent Special Enrollment Period. A dependent special enrollment period under subdivision (f)(2)(A) of this section shall be a period of not less than thirty (30) days and shall begin on the later of:

- (i) The date dependent coverage is made available; or
- (ii) The date of the marriage, birth, or adoption or placement for adoption as the case may be described in subdivision (f)(2)(A)(iii) of this section.

(C) No Waiting Period. If an individual seeks to enroll a dependent during the first thirty (30) days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

- (i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
- (ii) In the case of a dependent's birth, as of the date of such birth; or
- (iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(g) Use of Affiliation Period by Health Maintenance Organizations as Alternative to Preexisting Condition Exclusion.

(1) In General. In the case of a group health plan that offers medical care through coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:

(A) No preexisting condition exclusion is imposed with respect to coverage through the organization;

(B) The period is applied uniformly without regard to any health status-related factors;
and

(C) The period does not exceed two (2) months or three (3) months in the case of a late enrollee.

(2) Affiliation Period.

(A) Affiliation Period. The health maintenance organization is not required to provide health care services or benefits during the period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning. The affiliation period shall begin on the enrollment date.

(C) Runs Concurrently with Waiting Periods. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative Methods. A health maintenance organization described in subdivision (g)(1) of this section may use alternative methods from those described in the subdivision to address adverse selection as approved by the Insurance Commissioner.

23-86-305. Group health plan - Application of certain rules in determination of employer size.

(a) Application of Aggregation Rule for Employers. All persons treated as a single employer under subsections (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one (1) employer.

(b) Employers Not in Existence in Preceding Year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(c) Predecessors. Any reference in this subsection to an employer shall include a reference to any predecessor of the employer.

23-86-306. Prohibiting discrimination against individual participants and beneficiaries based on health status.

(a) Ineligibility to Enroll.

(1) In General. Subject to subdivision (a)(2) of this section, a group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan may not establish rules for eligibility including continued eligibility of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status;

(B) Medical condition including both physical and mental illnesses;

(C) Claims experience;

(D) Receipt of health care;

(E) Medical history;

(F) Genetic information;

(G) Evidence of insurability including conditions arising out of acts of domestic violence; or

(H) Disability.

(2) No Application to Benefits or Exclusions. To the extent consistent with § 23-86-304, subdivision (a)(1) of this section shall not be construed:

(A) To require a group health plan or group health insurance coverage to provide particular benefits other than those provided under the terms of such plan or coverage; or

(B) To prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) Construction. For purposes of subdivision (1) of this subsection, rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) In Premium Contributions.

(1) In General. A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan may not require any individual as a condition of enrollment or continued enrollment under the plan to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction. Nothing in subdivision (b)(1) of this section shall be construed:

(A) To restrict the amount that an employer may be charged for coverage under a group health plan; or

(B) To prevent a group health plan and a health insurance issuer offering group health insurance coverage from establishing otherwise lawful premium discounts, rebates, or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

23-86-307. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.

A group health plan which is a multiemployer plan or which is a multiple employer welfare arrangement may not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such a plan, other than:

(1) For nonpayment of contributions;

(2) For fraud or other intentional misrepresentation of material fact by the employer;

(3) For noncompliance with material plan provisions;

(4) Because the plan is ceasing to offer any coverage in a geographic area;

(5) In the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this subdivision uniformly without regard to the claims experience of employers or any health status-related factor in relation to the individuals or their dependents; and

(6) For failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

23-86-308. Rules of construction.

Nothing in this subchapter shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

23-86-309. Special rules relating to group health plans.

- (a) General Exception for Certain Small Group Health Plans. The requirements of this subchapter shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan for any plan year if, on the first day of such plan year, such plan has less than two (2) participants who are current employees.
- (b) Exception for Certain Benefits. The requirements of this subchapter shall not apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in § 23-86-310(a).
- (c) Exception for Certain Benefits if Certain Conditions Met.
- (1) Limited, Excepted Benefits. The requirements of this subchapter shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in § 23-86-310(b) if the benefits:
- (A) Are provided under a separate policy, certificate, or contract of insurance; or
 - (B) Are otherwise not an integral part of the plan.
- (2) Noncoordinated, Excepted Benefits. The requirements of this subchapter shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in § 23-86-310(c) if all of the following conditions are met:
- (A) The benefits are provided under a separate policy, certificate, or contract of insurance;
 - (B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and
 - (C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.
- (3) Supplemental Excepted Benefits. The requirements of this subchapter shall not apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in § 23-86-310(d) if the benefits are provided under a separate policy, certificate, or contract of insurance.
- (d) Treatment of partnerships.
- (1) Treatment as a Group Health Plan. Any plan, fund, or program which would not be, but for this subsection, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance or reimbursement or otherwise, shall be treated, subject to subdivision (d)(2) of this section as an employee welfare benefit plan which is a group health plan.

(2) Employer. In the case of a group health plan, the term "employer" also includes the partnership in relation to any partner.

(3) Participants of Group Health Plans. In the case of a group health plan, the term "participant" also includes:

(A) In connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership; or

(B) In connection with a group health plan maintained by a self-employed individual under which one or more employees are participants, the self-employed individual, if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

23-86-310. Excepted benefits.

For purposes of this section, the term "excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(1) Benefits not subject to requirements:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics;

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(2) Benefits not subject to requirements if offered separately:

(A) Limited scope dental or vision benefits;

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(C) Such other similar, limited benefits as specified in regulations;

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits:

(A) Coverage only for a specified disease or illness;

(B) Hospital indemnity or other fixed indemnity insurance;

(4) Benefits not subject to requirements if offered as separate insurance policy. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

23-86-311. Guaranteed renewability of coverage for employers in the group market.

(a) In General. Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small or large-group market in connection with a group

health plan, the issuer must renew or continue in force such coverage at the option of the sponsor of the plan.

(b) General Exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large-group market based only on one (1) or more of the following:

(1) Nonpayment of Premiums. The plan sponsor 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;

(2) Fraud. The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) Violation of Participation or Contribution Rules. The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules in the case of the small-group market or pursuant to applicable Arkansas law in the case of the large-group market;

(4) Termination of Coverage. The issuer is ceasing to offer coverage in such a market in accordance with subsection (c) of this section and applicable state law;

(5) Movement Outside Service Area. In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with the plan who lives, resides, or works in the service area of the issuer, or in the area for which the issuer is authorized to do business, and, in the case of the small-group market, the issuer would deny enrollment with respect to the plan under § 23-86-312(c)(1)(A);

(6) Association Membership Ceases. In the case of health insurance coverage that is made available in the small or large-group market, as the case may be, only through one (1) or more bona fide associations, the membership of an employer in the association on the basis of which the coverage is provided ceases but only if the coverage is terminated under this subdivision (b)(6) uniformly without regard to any health status-related factor relating to any covered individual;

(7)(A) If a health insurance issuer nonrenews or discontinues group health insurance coverage under subdivision (b)(1) of this section, the health insurance issuer shall provide written notice to the individual employees insured under the group health plan so that the employees will have no fewer than fourteen (14) days to acquire alternative health coverage without loss of creditable coverage due to a break in coverage, as provided under § 23-86-304(d)(4).

(B) The Insurance Commissioner shall determine by rule or regulation the form, content, and timing of the notice under subdivision (7)(A) of this section.

(c) Requirements for Uniform Termination of Coverage.

(1) Particular Type of Coverage Not Offered. In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large-group market, coverage of this type may be discontinued by the issuer in accordance with Arkansas law in such a market only if:

(A) The issuer provides notice to each plan sponsor provided coverage of this type in such a market and participants and beneficiaries covered under such coverage of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage;

(B) The issuer offers to each plan sponsor provided coverage of this type in such a market the option to purchase all or, in the case of the large-group market, any other health insurance coverage currently being offered by the issuer to a group health plan in such a market; and

(C) In exercising the option to discontinue coverage of this type and in offering the option of coverage under subdivision (c)(1)(B) of this section, the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2) Discontinuance of All Coverage.

(A) In General. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small-group market or the large-group market or both markets in this state, health insurance coverage may be discontinued by the issuer only in accordance with Arkansas law and if:

(i) The issuer provides notice to the Insurance Commissioner and to each plan sponsor and participants and beneficiaries covered under the coverage of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage; and

(ii) All health insurance issued or delivered for issuance in this state in such market or markets is discontinued and coverage under such health insurance coverage in such market or markets is not renewed.

(B) Prohibition on Market Reentry. In the case of a discontinuation under subdivision (c)(2)(A) of this section in a market, the issuer may not provide for the issuance of any health insurance coverage in the market in this state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan:

(1) In the large-group market; or

(2) In the small-group market if, for coverage that is available in such a market other than only through one (1) or more bona fide associations, such a modification is consistent with Arkansas law and effective on a uniform basis among group health plans with that product.

(e) Application to Coverage Offered Only Through Associations. In applying this subsection in the case of health insurance coverage that is made available by a health insurance issuer in the small or large-group market to employers only through one (1) or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such an employer.

23-86-312. Guaranteed availability of coverage for employers in the group market.

(a) Issuance of Coverage in the Small Group Market - In General. Subject to subsections (b) through (e) of this section, each health insurance issuer that offers health insurance coverage in the small-group market in Arkansas:

(1) Must accept every small employer in Arkansas that applies for such coverage; and

(2) Must accept for enrollment under the coverage every eligible individual as defined in § 23-86-303(8) who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan and may not place any restriction which is inconsistent with § 23-86-306 on an eligible individual being a participant or beneficiary.

(b) Special Rules for Network Plans.

(1) In General. In the case of a health insurance issuer that offers health insurance coverage in the small-group market through a network plan, the issuer may:

(A) Limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) Within the service area of such plan, deny such coverage to such employers if the issuer has demonstrated, if required, to the Insurance Commissioner that:

(i) It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

(ii) It is applying this subsection uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

(2) One Hundred Eighty-Day Suspension Upon Denial of Coverage. Upon denying health insurance coverage in any service area in accordance with subdivision (b)(1)(B) of this section, an issuer may not offer coverage in the small-group market within the service area in this state for a period of one hundred eighty (180) days after the date the coverage is denied.

(c) Application of Financial Capacity Limits.

(1) In General. A health insurance issuer may deny health insurance coverage in the small-group market in Arkansas if the issuer has demonstrated to the commissioner that:

(A) It does not have the financial reserves necessary to underwrite additional coverage; and

(B) It is applying this subdivision uniformly to all employers in the small-group market in Arkansas consistent with applicable Arkansas law and without regard to the claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

(2) One Hundred Eighty-Day Suspension Upon Denial of Coverage.

(A) Upon denying health insurance coverage in connection with group health plans in accordance with subdivision (c)(1) of this section, a health insurance issuer in Arkansas may not offer coverage in connection with group health plans in the small-group market in this state for a period of one hundred eighty (180) days after the date the coverage is denied or until the issuer has demonstrated to the commissioner that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(B) The commissioner may provide for the application of this subsection on a service-area-specific basis.

(d) Exception to Requirement for Failure to Meet Certain Minimum Participation or Contribution Rules - In General. Subsection (a) of this section shall not be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health plan in the small-group market, as allowed under Arkansas law.

(e) Exception for Coverage Offered Only to Bona Fide Association Members. Subsection (a) of this section shall not apply to health insurance coverage offered by a health insurance issuer if the coverage is made available in the small-group market only through one (1) or more bona fide associations as defined in § 23-86-303(2).

23-86-313. Disclosure of information.

(a) Disclosure of Information by Health Plan Issuers. In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer:

(1) Shall make a reasonable disclosure to such employer as part of its solicitation and sales materials of the availability of information described in subsection (b) of this section; and

(2) Upon request of such a small employer, provide such information.

(b) Information Described.

(1) In General. Subject to subdivision (b)(3) of this section, with respect to a health insurance issuer offering health insurance coverage to a small employer, information described in this section is information concerning:

(A) The provisions of such coverage concerning the issuer's right to change premium rates and the factors that may affect changes in premium rates;

(B) The provisions of such coverage relating to renewability of coverage;

(C) The provisions of such coverage relating to any preexisting condition exclusion; and

(D) The benefits and premiums available under all health insurance coverage for which the employer is qualified.

(2) Form of Information. Information under this section shall be provided to small employers in a manner determined by the Insurance Commissioner to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

(3) Exception. An issuer is not required under this section to disclose any information that is proprietary or trade secret information under applicable law.

23-86-314. Exclusion of certain plans.

(a) Exception for Certain Small Group Health Plans. The requirements of § 23-86-304, limitation on preexisting conditions, § 23-86-306, prohibiting discrimination based on health status, § 23-86-311, guaranteed renewability, § 23-86-312, guaranteed availability, and § 23-86-313, disclosure of information, of this subchapter shall not apply to any group health plan and health insurance coverage offered in connection with a group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two (2) participants who are current employees.

(b) Limitation on Application of Provisions Relating to Group Health Plans.

(1) In General. The requirements of §§ 23-86-304, 23-86-306, 23-86-311, 23-86-312 and 23-86-313 of this subchapter shall apply with respect to group health plans only:

(A) Subject to subdivision (b)(2) of this section, in the case of a plan that is a nonfederal governmental plan; and

(B) With respect to health insurance coverage offered in connection with a group health plan including such a plan that is a church plan or a governmental plan.

(2) Treatment of Nonfederal Governmental Plans.

(A) Election to be Excluded. If the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of §§ 23-86-304, 23-86-306, 23-86-311, 23-86-312 and 23-86-313 of this subchapter otherwise apply makes an election under this subdivision, then the requirements of such sections insofar as they apply directly to group health plans, and not merely to group health insurance coverage, shall not apply to such governmental plans for such period except as provided in this subsection.

(B) Period of Election. An election under subdivision (b)(2)(A) of this section shall apply:

(i) For a single specified plan year; or

(ii) In the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement. An election under subdivision (b)(2)(B)(i) of this section may be extended through subsequent elections under this subdivision.

(C) Notice to Enrollees. Under such an election, the plan shall provide for:

(i) Notice to enrollees on an annual basis and at the time of enrollment under the plan of the fact and consequences of such election; and

(ii) Certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with § 23-86-304(e).

(c) Exception for Certain Benefits. The requirements of §§ 23-86-304, 23-86-306, 23-86-312, 23-86-311 and 23-86-313 of this subchapter shall not apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in § 23-86-310(a)(1).

(d) Exception for Certain Benefits if Certain Conditions Met.

(1) Limited, Excepted Benefits. The requirements of §§ 23-86-304, 23-86-306, 23-86-311, 23-86-312 and 23-86-313 of this subchapter shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in § 23-86-310(b) if the benefits:

(A) Are provided under a separate policy, certificate, or contract of insurance; or

(B) Are otherwise not an integral part of the plan.

(2) Noncoordinated, Excepted Benefits. The requirements §§ 23-86-304, 23-86-306, 23-86-311, 23-86-312 and 23-86-313 of this subchapter shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in § 23-86-310(c) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) Supplemental Excepted Benefits. The requirements of this subsection shall not apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in § 23-86-310(d) if the benefits are provided under a separate policy, certificate, or contract of insurance.

Subchapter 4.
Freedom of Choice Among Health Benefit Plans.

23-86-401. Title.

This subchapter may be cited as the "Freedom of Choice Among Health Benefit Plans Act of 1999".

23-86-402. Legislative finding.

The General Assembly finds that:

- (1) Citizens covered by health benefit plans should have the opportunity to obtain health care services at an affordable price;
- (2) The cost of health benefit plans can vary depending upon the kind of arrangement the plan has with providers of health care services;
- (3) In order to provide affordable delivery of health care services, health benefit plans which utilize contractual arrangements with providers and encourage quality services at discounted prices should be promoted; and
- (4) Citizens should have the option to choose a health benefit plan that covers the services of any qualified health care provider.

23-86-403. Definitions.

As used in this subchapter:

- (1) "Benefit level" means obligation of the health maintenance organization or insurance company under its health benefit plan. The benefit level is actuarially determined considering the copayments, deductibles, and dollar limits of the health benefit plan;
- (2) "Covered health care services" means services rendered or products sold by a health care provider within the scope of the provider's license which are covered by a health benefit plan. The term may include hospital, medical, surgical, dental, vision, and pharmaceutical services or products;
- (3) "Covered person" means any person on whose behalf a health maintenance organization is obligated to make arrangements for or pay for covered health care service;
- (4) "Health benefit plan" means the agreement between an employer, association, state, county, or municipal agency and a health maintenance organization or insurance company which defines the covered services available;
- (5) "Health care provider" means a hospital, an ambulatory surgery center, an outpatient psychiatric center, a home health care agency, a skilled nursing facility, or an individual licensed to render covered health care services;
- (6) "Limited network plan" means a plan that arranges for or provides reimbursement for covered health care services to covered persons through a limited number of health care providers selected and employed or contracted by the health maintenance organization; and

(7) "Point of service plan" means a plan that provides payment of non-emergency, self-referred covered health care services obtained from providers who are not otherwise employed by nor under contract with the health maintenance organization.

23-86-404. Optional health benefit plans.

(a) A health maintenance organization may offer and issue health benefit plans that reimburse or arrange for covered health care services to covered persons through a limited network plan if:

(1) Such health maintenance organization provides itself, or arranges through an insurance company, for an annual option for covered persons to choose a health benefit plan or a point of service plan that reimburses or arranges for the covered health care services from any health care provider qualified to render such covered health care services;

(2) The difference in the benefit level of such optional health benefit plan or point-of-service plan shall not exceed twenty-five percent (25%) of the benefit level under the limited benefit plan;

(3) The employer or other group contract holder contracting with the health maintenance organization for a health benefit plan shall provide an equal contribution per covered person regardless of which option the covered person chooses pursuant to the provisions of this subchapter; and

(4) Under the optional health benefit plan or point-of-service plan, the rate of reimbursement for health providers out of the network shall be no higher than the normal and usual and customary rate charged by those out-of-network providers on a regular basis, provided that copayment, coinsurance and other cost-sharing features may be different for out-of-network providers and in-network providers.

(b) The pricing of the optional health benefit plan or point-of-service plan must provide an expected incurred loss ratio of not less than eighty percent (80%). The Insurance Commissioner shall promulgate rules and regulations as may be necessary to implement the provisions of this subchapter and to ensure the price of the option provided in this section bears a reasonable relationship to the costs and benefits of the limited network plan.

(c) This subchapter shall apply to any health benefit plan issued or renewed on or after January 1, 2000.

23-86-405. Effect of subchapter on pricing.

Nothing in this subchapter shall be construed to prohibit a health maintenance organization from pricing any health benefit plan according to sound actuarial principles.

23-86-406. Effect of subchapter on coverage of specific services.

Nothing in this subchapter shall be construed to require a health maintenance organization to cover any specific health care service.

Subchapter 5.
Small Employer Health Insurance Purchasing Group Act of 2001.

23-86-501. Title.

This subchapter shall be known and cited as the "Small Employer Health Insurance Purchasing Group Act of 2001".

23-86-502. Definitions.

For purposes of this subchapter:

- (1) "Commissioner" means the Insurance Commissioner of the State Insurance Department;
- (2) "Eligible employee" means an employee or individual who is a full-time employee of an eligible employer and is qualified to enroll in a health benefit plan offered through a health insurance purchasing group;
- (3) "Eligible employer" means an employer employing no more than one hundred (100) eligible employees;
- (4) "Employer", "employee", and "dependent", unless otherwise defined in this section, shall have the meanings applied to the terms with respect to the coverage under the laws of the state relating to the coverage and the issuer;
- (5) "Full time" means employees working at least thirty (30) hours per week for an eligible employer;
- (6) "Health benefits plan" means a group plan, group policy, or group contract for health care services, issued or delivered by a health insurance purchasing group health carrier, 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;
- (7) "Health insurer" means an insurer licensed to transact group accident and health insurance in this state;
- (8) "Health maintenance organization" means a health maintenance organization as defined in § 23-76-102 that is licensed to transact business in this state as a health maintenance organization under § 23-76-107;
- (9) "Health insurance purchasing group" means a health insurance purchasing group meeting the requirements of this subchapter;
- (10) "Health insurance purchasing group health carrier" means a health insurer, health maintenance organization, or hospital and medical service organization;
- (11) "Hospital and medical service corporation" means a hospital and medical service corporation as defined in § 23-75-101 that is licensed to transact business in this state as a hospital and medical service corporation under § 23-75-107;
- (12) "Large group" means a combination of two (2) or more eligible employers belonging to a health insurance purchasing group;
- (13) "Member" means an individual enrolled for health benefits coverage in a health insurance purchasing group;

- (14) "Purchaser" means an eligible employer that has contracted with a health insurance purchasing group for the purchase of health benefits coverage;
- (15)(A)(i) "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 the 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.
- (ii) Provided that for the purposes of the options provided by this subchapter, state-mandated health benefits that may be excluded, in whole or in part, shall not include any health care services or benefits that 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 state 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; and
- (16) "Total eligible employees" means five hundred (500) or more eligible employees.

23-86-503. Health insurance purchasing group organization requirements.

- (a) Each health insurance purchasing group shall be a nonprofit corporation operated under the direction of a board of directors that is composed of five (5) representatives of eligible employers.
- (b)(1)(A) Each health insurance purchasing group shall be composed of at least five hundred (500) eligible employees from one (1) or more eligible employers.
- (B) However, a health insurance purchasing group shall have twelve (12) months from the time of formation to reach the level of five hundred (500) eligible employees.
- (C) At the time of formation, the health insurance purchasing group shall have at least one hundred (100) eligible employees.
- (2)(A) Upon the failure of a health insurance purchasing group to maintain the required size restrictions described in this subsection, the health insurance purchasing group shall notify the Insurance Commissioner in writing that the health insurance purchasing group does not comply with the size requirements under subdivision (b)(1) of this section.
- (B) The health insurance purchasing group may then continue to operate the health benefits plan for its members but shall comply within sixty (60) calendar days with the size requirements of this section, or within a time period as determined by the commissioner.
- (C) Upon the failure of the health insurance purchasing group to maintain size requirements as required under this section, after sixty (60) calendar days or after the time period determined by the commissioner, the health insurance purchasing group may then be terminated following notice and hearing before the commissioner.
- (c)(1)(A) Subject to the provisions of this subchapter, a health insurance purchasing group shall permit any eligible employer that meets the membership requirements of the health insurance purchasing group to contract with the health insurance purchasing group for the purchase of a health benefits plan for its eligible employees and dependents of those eligible employees.

(B) The health insurance purchasing group may not vary conditions of eligibility, including premium rates and membership fees, for any employer meeting the membership requirements of the health insurance purchasing group, nor may it vary conditions of eligibility for any employee to qualify for a health insurance purchasing group health benefits plan offered to the eligible employer by the group health insurance purchasing group.

(2)(A) A contract shall provide that the purchaser agrees not to obtain or sponsor a health benefits plan on behalf of any eligible employees and their dependents other than through the health insurance purchasing group.

(B) This shall not be construed to apply to an eligible individual who resides in an area for which no coverage is offered by a health insurance purchasing group health carrier.

(3)(A)(i) Under rules established to carry out this subchapter with respect to an eligible employer that has a purchaser contract with a health insurance purchasing group, individuals who are eligible employees of an eligible employer may enroll for a health benefits plan offered by a health insurance purchasing group health carrier.

(ii) This may include coverage for dependents of the enrolling employees if this coverage is offered.

(B) The employees may enroll for health benefits provided through their employer's contract with a health insurance purchasing group.

(4) A health insurance purchasing group shall not deny enrollment as a member to an individual who is an eligible employee or dependent of an employee qualified to be enrolled based on health status-related factors except as may be permitted by law.

(5) In the case of members enrolled in a health benefits plan offered by a health insurance purchasing group health carrier, the health insurance purchasing group shall provide for an annual open enrollment period of thirty (30) calendar days during which the members may change the coverage option in which the members are enrolled.

(6)(A) Nothing in this subsection shall preclude a health insurance purchasing group from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subdivision (c)(5) of this section.

(B) The rules shall be applied consistently to all purchasers and members within the health insurance purchasing group and shall not be based in any manner on health status-related factors and shall not conflict with sections of this subchapter.

(d)(1) Each health insurance purchasing group shall annually file with the commissioner:

(A) A description of its plan of operation, including each of the products it intends to sell;

(B) A description of its marketing methods and materials; and

(C) A description of its membership and disclosure requirements or other information as required by the commissioner through rules and regulations.

(2) The plan of operation filed with the commissioner by the health insurance purchasing group pursuant to this subsection shall be deemed approved sixty (60) calendar days after the date of filing unless additional time is requested by the commissioner to review the plan.

(e) Each health insurance purchasing group shall be considered a large group for purposes of application of the Arkansas Insurance Code to the activities and health

benefit plans of the health insurance purchasing group unless stated otherwise in this subchapter.

(f) No purchaser, health insurance purchasing group, health maintenance organization, or health insurer providing coverage to a health insurance purchasing group shall be subject to any provisions in § 26-57-601 et seq. for insurance premiums collected for health benefit plans of health insurance purchasing groups.

23-86-504. Health insurance purchasing group health benefits coverage requirements.

(a) Each health insurance purchasing group, in conjunction with a health insurance purchasing group health carrier, shall make available a health benefits plan in the manner described in this section to all eligible employers and eligible employees at rates, including employer's and employees' share, on a policy-specific or product-specific basis that may vary only as permitted under law.

(b) Subject to subsection (c) of this section, a health insurance purchasing group shall not offer a health benefits plan that unfairly discriminates against eligible employees.

(c) Nothing in this subchapter shall be construed as requiring a health insurance purchasing group health carrier to provide coverage outside the service area of the insurer or organization.

(d) Each health insurance purchasing group shall provide a health benefits plan only through contracts with health insurance purchasing group health carriers and shall not assume insurance risk with respect to the coverage.

(e) Except as provided in this subchapter, the health insurance purchasing group may provide a health benefits plan in whole or in part, not subject to state-mandated health benefits, except those required in the Arkansas Health Insurance Portability and Accountability Act of 1997, § 23-86-301 et seq.

(f) The health insurance purchasing group shall offer at least two (2) types of plans including one (1) plan providing a choice of deductibles with state-mandated health benefits.

(g) The health insurance purchasing group may also offer a health benefits plan not subject to state-mandated health benefits that does not contain standard provisions or rights required to be present in a health benefits plan pursuant to law or regulations unrelated to a specific health illness, injury, or condition of the insured, for the provisions as may be determined by rules and regulations of the Insurance Commissioner.

(h)(1) Every health benefits plan offered through a health insurance purchasing group shall:

(A) Be underwritten by a health insurance purchasing group health carrier that:

(i) Is licensed or otherwise regulated under state law;

(ii) Meets all applicable state standards relating to consumer protection, including, but not limited to, state solvency and market conduct; and

(iii) Offers the coverage under a contract with the health insurance purchasing group;

(B) Be approved or otherwise permitted to be offered under law;

(C) Provide full portability of creditable coverage for individuals who remain members of the same health insurance purchasing group, notwithstanding that they change the eligible employer through which they are members; and

(D) Comply with the provisions of the Arkansas Insurance Code in their sales and solicitation of insurance including, but not limited to, the Trade Practices Act, § 23-66-201 et seq., and the requirements of §§ 23-64-201 and 23-64-102(1) that all insurance must be sold by an agent licensed by the State Insurance Department.

(2)(A) Any agent referenced in subdivision (h)(1)(D) of this section shall be required to obtain at least two (2) hours of continuing education on a health insurance purchasing group or the plans the health insurance purchasing group sponsors each year, or both.

(B) This requirement shall be considered as part of the continuing education requirements provided in § 23-64-301 and shall not preempt or conflict with the provision.

(i) A health insurance purchasing group shall be exempt from the requirements of §§ 23-86-201 - 23-86-204 and 23-86-207 - 23-86-209.

(j) Nothing in this subchapter shall be construed as precluding a health insurance purchasing group health carrier from offering a health benefits plan through a health insurance purchasing group by establishing premium discounts for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, so long as the programs are agreed to in advance by the health insurance purchasing group and comply with all other provisions of this subchapter and do not discriminate among similarly situated members.

23-86-505. Notice requirements.

In each sale of a health benefits plan to a proposed eligible employer through a health insurance purchasing group in which the health insurance purchasing group offers an option to an eligible employer to obtain a health benefits plan that, either in whole or in part, does not provide state-mandated health benefits or does not contain standard provisions as may be determined by rules and regulations of the Insurance Commissioner, the health insurance purchasing group, after the employer has selected its health benefit plan, shall provide to each eligible employee of the employer a written notice, in a form and manner as prescribed by rule or regulation promulgated by the commissioner, that one (1) or more mandated benefits are not included in the health benefit plan.

23-86-506. Health insurance purchasing group administrative services to members.

(a)(1) Each health insurance purchasing group may provide administrative services for its members.

(2) The services may include, but are not limited to, accounting, billing, enrollment information, and employee coverage status reports.

(b) The health insurance purchasing group may delegate or contract its billing and other administrative duties to a third-party administrator as defined under § 23-92-201 in compliance with the Arkansas Insurance Code, § 23-60-101 et seq.

(c) Nothing in this section shall be construed as preventing a health insurance purchasing group from serving as an administrative service organization to any entity.

(d)(1) Each health insurance purchasing group shall collect and disseminate or arrange for the collection and dissemination of consumer-oriented information on the scope, cost,

and enrollee satisfaction of all coverage options offered through the health insurance purchasing group to its members.

(2) The information shall be defined by the health insurance purchasing group and shall be in a manner appropriate to the type of coverage offered.

(3) To the extent practicable, the information shall include information on provider performance, locations, and hours of operation of providers, outcomes, and similar matters.

(4) Nothing in this section shall be construed as preventing the dissemination of the information or other information by the health insurance purchasing group or by the health care insurer, health maintenance organization, or organization through electronic or other means.

(e) The contract between a health insurance purchasing group and a health insurance purchasing group health carrier shall provide that the health insurance purchasing group may collect premiums on behalf of the issuer for coverage, less a predetermined administrative charge negotiated by the health insurance purchasing group and the issuer.

23-86-507. Filing and form filing requirements.

Each health insurance purchasing group shall file forms as may be described by rules and regulations of the Insurance Commissioner.

23-86-508. Prevention of conflicts of interest.

(a) A member of a board of directors of a health insurance purchasing group shall not serve as an employee or paid consultant to the health insurance purchasing group, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

(b) An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a health insurance purchasing group or as an employee of the health insurance purchasing group, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in an organization from whom the health insurance purchasing group receives contributions, grants, or other funds not connected with a contract for coverage through the health insurance purchasing group.

(c)(1) An individual who is serving on a board of directors of a health insurance purchasing group as a representative described in subsection (b) of this section shall not be employed by or affiliated with a health insurance purchasing group health carrier.

(2) For purposes of subdivision (c)(1) of this section, the term "affiliated" does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance purchasing group health carrier.

23-86-509. Health insurance purchasing group operations and coordination.

(a) Nothing in this subchapter shall be construed as preventing one (1) or more health insurance purchasing groups serving different areas, whether or not contiguous, from providing for some or all of the following through a single administrative organization or otherwise:

- (1) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different health insurance purchasing groups; or
- (2) Providing for crediting of deductibles and other cost-sharing for individuals who are provided a health benefits plan through the health insurance purchasing group or affiliated health insurance purchasing group after:
 - (A) A change of eligible employers through which the coverage is provided; or
 - (B) A change in place of employment to an area not served by the previous health insurance purchasing group.
- (b) Nothing in this subchapter shall be construed as precluding a health insurance purchasing group from providing for adjustments in amounts distributed among the health insurance purchasing group health carrier offering a health benefits plan through the health insurance purchasing group, based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.
- (c) Nothing in this subchapter shall be construed as precluding a health insurance purchasing group from establishing minimum participation and contribution rules for eligible employers that apply to become purchasers in the health insurance purchasing group, so long as the rules are applied uniformly for all health insurance purchasing group health carriers.

23-86-510. Premium rates.

- (a) The health insurance purchasing group may determine what rating characteristics it will allow in the health benefit plan, including, but not limited to, age, sex, industry, geography, or health.
- (b) If health is used as a rating characteristic, then the rates for the size groups two (2) through twenty-five (25) will be subject to the small group rating law as required in §§ 23-86-201 - 23-86-204 and 23-86-207 - 23-86-209, but may be considered separate from any small groups sold outside the health insurance purchasing group.

23-86-511. Rules and regulations.

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

23-86-512. Health insurance purchasing group health carrier market.

No health insurance purchasing group health carrier shall be required to offer health insurance purchasing group health benefits plans, or health benefits plans not subject to state-mandated health benefits, to non health insurance purchasing group organizations, associations, or employer groups, including, but not limited to, the small employer health insurance group marketplace in this state.