State of Arkansas
95th General Assembly
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A Bill

HOUSE BILL 1420

By: Representative Steimel
By: Senator J. Boyd

For An Act To Be Entitled

AN ACT TO ENACT THE STATE INSURANCE DEPARTMENT'S GENERAL OMNIBUS AMENDMENT OF ARKANSAS INSURANCE CODE; TO AMEND THE ARKANSAS WORKERS' COMPENSATION INSURANCE PLAN; TO AMEND THE LAW CONCERNING RECIPROCAL INSURERS; TO CLARIFY AN ATTORNEY'S BOND REQUIREMENT; TO AMEND THE LAW CONCERNING BENEFITS FOR ALCOHOL AND DRUG DEPENDENCY TREATMENT; TO AMEND THE LAW CONCERNING SERVICE OF PROCESS IN SUITS INVOLVING INSURERS; TO REPEAL THE COMPREHENSIVE HEALTH INSURANCE POOL ACT; TO REPEAL THE MINIMUM BENEFITS FOR MENTAL ILLNESS IN GROUP ACCIDENT AND HEALTH INSURANCE POLICIES OR SUBSCRIBER'S CONTRACTS; TO AMEND THE ARKANSAS MENTAL HEALTH PARITY ACT OF 2009; AND FOR OTHER PURPOSES.

Subtitle

TO ENACT THE STATE INSURANCE DEPARTMENT'S GENERAL OMNIBUS AMENDMENT OF ARKANSAS INSURANCE CODE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 23-67-304(e), concerning the ability of the Insurance Commissioner to delegate responsibility under the Arkansas Workers' Compensation Insurance Plan, is amended to read as follows:

(e)(1)(A) ~~At his or her discretion, the~~ The Insurance Commissioner ~~is authorized to~~ may delegate all or any part of the commissioner's

responsibility to establish and operate the plan.

(B) However, any such plan, or plan of operation, and any amendments thereto must receive the prior approval of the commissioner.

(2) Any person or entity to whom the establishment, implementation, or operation of the plan is delegated pursuant to this subsection shall file with and obtain the approval of the commissioner as to all policy forms, rates, or supplementary rate information necessary to effectuate the plan.

(3)(A) In delegating all or part of the commissioner's responsibility, the commissioner shall not approve any plan or filing that abrogates or restricts his or her authority to select the plan administrator or servicing carriers.

(B) The commissioner shall competitively select the organization or organizations to whom the responsibility of plan administrator shall be delegated.

(C) If the administration of the plan is delegated, the plan administrator or administrators shall ~~have an office in Arkansas~~ be adequately staffed, outfitted, and maintained to provide the plan services delegated.

(D) The commissioner shall specify duties and functions of plan administrators and may structure and delegate administrative functions separately such as, but not limited to, rates, forms, and statistics for the best operation of the plan.

(4) Under the provisions of this subsection, the commissioner shall vigorously promote competition for the designation of the plan administrator and servicing carrier for the most effective operation of the plan.

(5)(A) The ~~office~~ plan administrator and personnel in Arkansas ~~is established~~ are placed in their positions to improve services provided by the plan, to promote and secure courteous and timely service, and to assure that the minimum standards as provided under subdivision (f)(2) of this section are met.

(B) The ~~office~~ plan administrator and personnel in Arkansas shall also assist employers or agents with questions, problems, or complaints pertaining to the servicing carriers and secure and expedite prompt and fair treatment to employers for servicing carrier errors and

service failures.

(6)(A) The Arkansas ~~office~~ manager shall have the authority to intervene with servicing carriers to secure an adequate level of service and prevent servicing carriers from imposing unreasonable demands or actions.

(B) The ~~office~~ manager shall keep a record of all employer or agent problems and complaints by a servicing carrier, including a description of the problem. This record shall be provided to the commissioner within sixty (60) days of each calendar year or upon the request of the commissioner.

(C) The manager shall promptly notify the commissioner of any problems upon a request by an employer.

SECTION 2. Arkansas Code § 23-70-110(a)(1), concerning the attorney's bond required of a domestic reciprocal insurer, is amended to read as follows:

(a)(1)(A) Concurrently with the filing of the declaration provided for in § 23-70-106, the attorney of a domestic or foreign reciprocal insurer shall file with the Insurance Commissioner a bond in favor of this state for the benefit of all persons damaged as a result of breach by the attorney of the conditions of his or her bond as ~~set forth~~ stated in subdivision (a)(2) of this section.

(B) The bond under subdivision (a)(1)(A) of this section shall be:

(i) ~~executed~~ Executed by the attorney and by an authorized corporate surety; and

(ii) ~~shall be subject~~ Subject to the commissioner's approval.

SECTION 3. Arkansas Code § 23-79-139 is repealed.

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

~~(a)(1) Every insurer, hospital and medical service corporation, and health maintenance organization transacting accident and health insurance in this state shall offer and make available under all group policies, contracts, and plans providing hospital and medical coverage on an expense incurred, service, or prepaid basis benefits for the necessary care and~~

~~treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors, except as provided in this section.~~

~~(2)(A) The offer for these benefits shall be subject to the right of the policy or contract holder to reject the coverage or select any alternative level of benefits.~~

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

~~(b) Any benefits provided under alcohol or drug dependency coverage shall be determined as necessary care and treatment in an alcohol or drug dependency treatment facility or care and treatment in a hospital.~~

~~(c) Treatment may include detoxification, administration of a therapeutic regimen for the treatment of alcohol or drug dependent or substance abusing persons, and related services.~~

~~(d) The facility or unit may be:~~

~~(1) A unit within a general hospital or an attached or freestanding unit of a general hospital;~~

~~(2) A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital; or~~

~~(3) A freestanding facility specializing in treatment of persons who are substance abusers or are alcohol or drug dependent, and may be identified as "chemical dependency, substance abuse, alcoholism, or drug abuse facilities", "social setting detoxification facilities", and "medical detoxification facilities", or by other names if the purpose is to provide treatment of alcohol or drug dependent or substance abusing persons, but shall not include halfway houses or recovery farms.~~

~~(e) Every policy or contract of insurance that provides benefits for alcohol or drug dependency treatment and that provides total annual benefits for all illnesses in excess of six thousand dollars ($6,000) is subject to the following conditions:~~

~~(1) The policy or contract shall provide, for each twenty-four-month period, a minimum benefit of six thousand dollars ($6,000) for the necessary care and treatment of alcohol or drug dependency;~~

~~(2) No more than one-half (½) of the policy's or contract's maximum benefits for alcohol or drug dependency for a twenty-four-month~~

~~period shall be paid for the necessary care and treatment of alcohol or drug dependency in any thirty-consecutive-day period; and~~

~~(3) The policy or contract shall provide a minimum benefit of twelve thousand dollars ($12,000) for the necessary care and treatment of alcohol or drug dependency for the life of the recipient of benefits.~~

~~(f) For the purposes of this section, the term "alcohol or drug dependency treatment facility" means a public or private facility or unit in a facility that provides treatment twenty-four (24) hours a day for alcohol or drug dependency or substance abuse, that provides a program for the treatment of alcohol or other drug dependency under a written treatment plan approved and monitored by a physician, and that is also properly licensed or accredited to provide those services by the Division of Aging, Adult, and Behavioral Health Services of the Department of Human Services.~~

~~(g) Nothing in this section shall prohibit any certificate or contract from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for alcohol or drug dependency.~~

~~(h) As used in this section, "alcohol or drug dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and that may, but need not, include a pattern of tolerance and withdrawal.~~

~~(i) This section shall apply to group policies or contracts delivered or issued for delivery or renewed in this state after November 17, 1987, but shall not apply to blanket short-term travel accident only, limited or specified disease, conversion policies or contracts, nor to policies or contracts referred to as Medicare supplement policies, designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act.~~

SECTION 4. Arkansas Code § 23-79-205(a), concerning service of process against an insurer, is amended to read as follows:

(a) In any suit brought in this state against an insurer, process may be served upon the insurer as follows:

(1) As to domestic insurers, service of process may be had only in the manner as provided by ~~§ 16-58-124~~ the Arkansas Rules of Civil

Procedure;

(2) As to licensed foreign or alien insurers, service on and after January 1, 2003, may be made as provided in § 23-63-301 et seq.; and

(3) As to suits against unauthorized insurers, service of process shall be made as provided in §§ 23-65-101 — 23-65-104, § 23-65-201 et seq., and §§ 23-65-301 — 23-65-318 for unauthorized insurers and surplus lines.

SECTION 5. Arkansas Code Title 23, Chapter 79, Subchapter 5, is repealed.

~~Subchapter 5 — Comprehensive Health Insurance Pool Act~~

~~23-79-501. Purpose.~~

~~(a)(1) Acts 1995, No. 1339, established the Arkansas Comprehensive Health Insurance Pool as a state program that was intended to provide an alternate market for health insurance for certain uninsurable Arkansas residents, and further this subchapter is intended to provide for the successor entity that will provide the acceptable alternative mechanism as described in the Health Insurance Portability and Accountability Act of 1996 for providing portable and accessible individual health insurance coverage for federally eligible individuals as defined in this subchapter.~~

~~(2) This subchapter further is intended to provide a health insurance coverage option for persons eligible for a federal income tax credit under section 35 of the Internal Revenue Code, as created by the Trade Adjustment Assistance Reform Act of 2002 or as subsequently amended.~~

~~(b) The General Assembly declares that it intends for this program to provide portable and accessible individual health insurance coverage for every individual who qualifies for coverage in accordance with § 23-79-509(b) as a federally eligible individual or as a qualified trade adjustment assistance eligible person but does not intend for every eligible person who qualifies for pool coverage in accordance with § 23-79-509 to be guaranteed a right to be issued a policy under this pool as a matter of entitlement.~~

~~23-79-502. Short title.~~

~~This subchapter may be cited as the "Comprehensive Health Insurance Pool Act", and is amendatory to the Arkansas Insurance Code and the~~

~~provisions of the Arkansas Insurance Code which are not in conflict with this subchapter are applicable to this subchapter.~~

~~23-79-503. Definitions.~~

~~As used in this subchapter:~~

~~(1) "Agent" means any person who is licensed to sell health insurance in this state;~~

~~(2) "Board" means the Board of Directors of the Arkansas Comprehensive Health Insurance Pool;~~

~~(3) "Church plan" has the same meaning given that term in the Health Insurance Portability and Accountability Act of 1996;~~

~~(4) "Commissioner" means the Insurance Commissioner;~~

~~(5) "Continuation coverage" means continuation of coverage under a group health plan or other health insurance coverage for former employees or dependents of former employees that would otherwise have terminated under the terms of that coverage pursuant to any continuation provisions under federal or state law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, § 23-86-114 of the Arkansas Insurance Code, or any other similar requirement in another state;~~

~~(6) "Covered person" means a person who is and continues to remain eligible for pool coverage and is covered under one (1) of the plans offered by the pool;~~

~~(7)(A) "Creditable coverage" means, with respect to a federally eligible individual or a qualified trade adjustment assistance eligible person, coverage of the individual under any of the following:~~

~~(i) A group health plan;~~

~~(ii) Health insurance coverage, including group health insurance coverage;~~

~~(iii) Medicare;~~

~~(iv) Medical assistance;~~

~~(v) 10 U.S.C. § 1071 et seq.;~~

~~(vi) A medical care program of the Indian Health Service or of a tribal organization;~~

~~(vii) A state health benefits risk pool;~~

~~(viii) A health plan offered under 5 U.S.C. § 8901 et seq.;~~

~~(ix) A public health plan, as defined in regulations consistent with section 104 of the Health Insurance Portability and Accountability Act of 1996 that may be promulgated by the Secretary of the United States Department of Health and Human Services; and~~

~~(x) A health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. § 2504(e).~~

~~(B) "Creditable coverage" does not include:~~

~~(i) Coverage consisting solely of coverage of excepted benefits as defined in section 2791(C) of Title XXVII of the Public Health Service Act, 42 U.S.C. § 300gg-91; or~~

~~(ii)(a) Any period of coverage under subdivisions (7)(A)(i)-(x) of this section that occurred before a break of more than sixty-three (63) days during all of which the individual was not covered under subdivisions (7)(A)(i)-(x) of this section.~~

~~(b) Any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into account in determining if there has been a break of more than sixty-three (63) days in any creditable coverage;~~

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

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

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

~~(A) For whom:~~

~~(i) As of the date on which the individual seeks pool coverage under § 23-79-509, the aggregate of the periods of creditable coverage is eighteen (18) or more months; and~~

~~(ii) The most recent prior creditable coverage was under group health insurance coverage offered by an insurer, a group health plan, a governmental plan, a church plan, or health insurance coverage offered in connection with any such plans;~~

~~(B) Who is not eligible for coverage under:~~

~~(i) A group health plan;~~

~~(ii) Part A or Part B of Medicare; or~~

~~(iii) Medical assistance and does not have other health insurance coverage;~~

~~(C) With respect to whom the most recent coverage within the coverage period described in subdivision (10)(A)(i) of this section was not terminated based upon a factor related to nonpayment of premiums or fraud;~~

~~(D) If the individual has been offered the option of continuation coverage under a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation provision or under a similar state program, who elected such coverage; and~~

~~(E) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under such a provision or program;~~

~~(11) "Governmental plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;~~

~~(12) "Group health plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;~~

~~(13)(A) "Health insurance" means any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, hospital or medical service corporation, health maintenance organization, or any other healthcare plan or arrangement that pays for or furnishes medical or healthcare services whether by insurance or otherwise and includes any excess or stop-loss coverage.~~

~~(B) "Health insurance" does not include long-term care, disability income, short-term, accident, dental-only, vision-only, fixed indemnity, limited-benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;~~

~~(14) "Health maintenance organization" shall have the same meaning as defined in § 23-76-102;~~

~~(15) "Hospital" shall have the same meaning as defined in § 20-9-~~

~~201;~~

~~(16) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market but does not include short-term, limited-duration insurance;~~

~~(17)(A) "Insurer" means any entity that provides health insurance, including excess or stop-loss health insurance, in the State of Arkansas.~~

~~(B) For the purposes of this subchapter, "insurer" includes an insurance company, medical services plans, hospital plans, hospital medical service corporations, health maintenance organizations, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;~~

~~(18) "Medical assistance" means the state medical assistance program provided under Title XIX of the Social Security Act or under any similar program of healthcare benefits in a state other than Arkansas;~~

~~(19)(A)(i) "Medically necessary" means that a service, drug, supply, or article is necessary and appropriate for the diagnosis or treatment of an illness or injury in accord with generally accepted standards of medical practice at the time the service, drug, or supply is provided.~~

~~(ii) When specifically applied to a confinement, "medically necessary" further means that the diagnosis or treatment of the covered person's medical symptoms or condition cannot be safely provided to that person as an outpatient.~~

~~(B) A service, drug, supply, or article shall not be medically necessary if it:~~

~~(i) Is investigational, experimental, or for research purposes;~~

~~(ii) Is provided solely for the convenience of the patient, the patient's family, physician, hospital, or any other provider;~~

~~(iii) Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;~~

~~(iv) Could have been omitted without adversely affecting the covered person's condition or the quality of medical care; or~~

~~(v) Involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug~~

~~Administration;~~

~~(20) "Medicare" means coverage under Part A and Part B of Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.;~~

~~(21) "Physician" means a person licensed to practice medicine as duly licensed by the State of Arkansas;~~

~~(22) "Plan" means the comprehensive health insurance plan as adopted by the board or by rule;~~

~~(23) "Plan administrator" means the insurer designated under § 23-79-508 to carry out the provisions of the plan of operation;~~

~~(24) "Plan of operation" means the plan of operation of the pool, including articles, bylaws, and operating rules adopted by the board pursuant to this subchapter;~~

~~(25) "Provider" means any hospital, skilled nursing facility, hospice, home health agency, physician, pharmacist, or any other person or entity licensed in Arkansas to furnish medical care, articles, and supplies;~~

~~(26) "Qualified high-risk pool" has the same meaning given that term in the Health Insurance Portability and Accountability Act of 1996;~~

~~(27) "Qualified trade adjustment assistance eligible person" means a person who is a trade adjustment assistance eligible person as defined by this section and for whom, on the date an application for the individual is received by the pool under § 23-79-509, has an aggregate of at least three (3) months of creditable coverage without a break in coverage of sixty-three (63) days or more;~~

~~(28) "Resident eligible person" means a person who:~~

~~(A) Has been legally domiciled in the State of Arkansas for a period of at least:~~

~~(i) Ninety (90) days and continues to be domiciled in Arkansas; or~~

~~(ii) Thirty (30) days, continues to be domiciled in Arkansas, and was covered under a qualified high-risk pool in another state up until sixty-three (63) days or less prior to the date that the pool receives his or her application for coverage; and~~

~~(B) Is not eligible for coverage under:~~

~~(i) A group health plan;~~

~~(ii) Part A or Part B of Medicare; or~~

~~(iii) Medical assistance as defined in this section~~

~~and does not have other health insurance coverage as defined in this section; and~~

~~(29) "Trade adjustment assistance eligible person" means a person who is legally domiciled in the State of Arkansas on the date of application to the pool and is eligible for the tax credit for health insurance coverage premiums under section 35 of the Internal Revenue Code of 1986.~~

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

~~(a) There is created a nonprofit legal entity to be known as the "Arkansas Comprehensive Health Insurance Pool" as the successor entity to the nonprofit legal entity established by Acts 1995, No. 1339.~~

~~(b)(1) The pool shall operate subject to the supervision and control of the Board of Directors of the Arkansas Comprehensive Health Insurance Pool. The pool is created as a political subdivision, instrumentality, and body politic of the State of Arkansas, and, as such, is not a state agency.~~

~~(2) Except to the extent defined in this subchapter, the pool will be exempt from:~~

~~(A) All state, county, and local taxes;~~

~~(B) The Arkansas Procurement Law, § 19-11-201 et seq.;~~

~~(C) The Freedom of Information Act of 1967, § 25-19-101 et seq.; and~~

~~(D) The Arkansas Administrative Procedure Act, § 25-15-201 et seq.~~

~~(3) The board shall consist of the following seven (7) members to be appointed by the Insurance Commissioner:~~

~~(A) Two (2) current or former representatives of insurance companies licensed to do business in the State of Arkansas;~~

~~(B) Two (2) current or former representatives of health maintenance organizations licensed to do business in the State of Arkansas;~~

~~(C) One (1) member of a health-related profession licensed in the State of Arkansas;~~

~~(D) One (1) member from the general public who is not associated with the medical profession, a hospital, or an insurer; and~~

~~(E) One (1) member to represent a group considered to be uninsurable.~~

~~(4) In making appointments to the board, the commissioner shall~~

~~strive to ensure that at least one (1) person serving on the board is at least sixty (60) years of age.~~

~~(5) All terms shall be for three (3) years.~~

~~(6) The board shall elect one (1) of its members as chair.~~

~~(7) Any vacancy in the board occurring for any reason other than the expiration of a term shall be filled for the unexpired term in the same manner as the original appointment.~~

~~(8) Members of the board may be reimbursed from moneys of the pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the board but shall not otherwise be compensated for their services.~~

~~(c) All insurers, as a condition of doing business in the State of Arkansas, shall participate in the pool by paying the assessments, submitting the reports, and providing the information required by the board or the commissioner to implement the provisions of this subchapter.~~

~~(d)(1) Neither the board nor its employees shall be liable for any obligations of the pool.~~

~~(2) No board member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this subchapter.~~

~~(3) The board may provide in its bylaws or rules for indemnification of, and legal representation for, the board members and employees.~~

~~23-79-505. Plan of operation.~~

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

~~(2) If the board fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of~~

~~directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of this section. The rules shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner.~~

~~(b) The plan of operation shall:~~

~~(1) Establish procedures for operation of the pool;~~

~~(2) Establish procedures for selecting a plan administrator in accordance with § 23-79-508;~~

~~(3) Create a fund, under management of the board, to pay administrative claims and other expenses of the pool;~~

~~(4) Establish procedures for the handling, accounting, and auditing of assets, moneys, and claims of the pool and the plan administrator;~~

~~(5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and the procedures for enrollment and to maintain public awareness of the plan;~~

~~(6)(A) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board after completion of the review.~~

~~(B) The board shall retain all written complaints regarding the plan for at least three (3) years; and~~

~~(7) Provide for other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this subchapter.~~

~~23-79-506. Powers.~~

~~(a)(1) The Arkansas Comprehensive Health Insurance Pool shall have the general powers and authority granted under the laws of the State of Arkansas to health insurers and, in addition thereto, the specific authority to:~~

~~(A) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this subchapter;~~

~~(B) Sue or be sued, including taking any legal actions necessary or proper;~~

~~(C) Take such legal action as necessary, including without limitation:~~

~~(i) Avoiding the payment of improper claims against the pool or the coverage provided by or through the pool;~~

~~(ii) Recovering any amounts erroneously or improperly paid by the pool;~~

~~(iii) Recovering any amounts paid by the pool as a result of mistake of fact or law;~~

~~(iv) Recovering other amounts due the pool; or~~

~~(v) Coordinating legal action with the Insurance Commissioner to enforce the provisions of this subchapter;~~

~~(D)(i) Establish and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas, deductibles, copayments, coinsurance, and any other actuarial function appropriate to the operation of the pool.~~

~~(ii) Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographical variation in claim costs and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;~~

~~(E) Issue policies of insurance in accordance with the requirements of this subchapter. All policy forms shall be subject to the approval of the commissioner;~~

~~(F) Authorize the plan administrator to prepare and distribute certificate of eligibility forms and enrollment instruction forms to agents and to the general public;~~

~~(G) Provide and employ cost-containment measures and requirements, including without limitation preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purposes of making the plan more cost effective;~~

~~(H) Design, utilize, contract, or otherwise arrange the delivery of cost-effective healthcare services, including establishing or contracting directly or through the plan administrator with preferred provider organizations, health maintenance organizations, physician hospital organizations, or other limited network provider arrangements;~~

~~(I) Borrow money to effect the purposes of the pool. Any~~

~~notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets;~~

~~(J) Pledge, assign, and grant a security interest in any of the assessments authorized by this subchapter or other assets of the pool in order to secure any notes or other evidences of indebtedness of the pool;~~

~~(K) Provide reinsurance of risks incurred by the pool;~~

~~(L) Provide additional types of plans to provide optional coverages, including Medicare supplement health insurance and health savings accounts that comply with applicable federal law as in effect January 1, 2005;~~

~~(M) Enter into reciprocal agreements with other comparable state plans in order to provide coverage for persons who move between states and are covered by such other states' plans; and~~

~~(N) Establish lifetime maximum benefits under § 23-79-510(a)(2)(W) for any person covered by a plan.~~

~~(2) In addition to the other powers granted by the Arkansas Insurance Code, the commissioner may impose, after notice and hearing in accordance with the provisions of the Arkansas Insurance Code, a monetary penalty upon any insurer or suspend or revoke the certificate of authority to transact insurance in the State of Arkansas of any insurer that fails to pay an assessment or otherwise file any report or furnish information required to be filed with the Board of Directors of the Arkansas Comprehensive Health Insurance Pool pursuant to the board's direction that the board believes is necessary in order for the board to perform its duties under this subchapter.~~

~~(b) All outstanding contracts executed by the Board of Directors of the State Comprehensive Health Insurance Pool created by Acts 1995, No. 1339, shall be deemed continuing obligations of the board created by this subchapter.~~

~~(c) As provided for in § 23-79-502, any health insurance benefit not provided for in this subchapter shall be deemed to be in conflict with and therefore inapplicable to the provisions of this subchapter.~~

~~23-79-507. Funding of pool.~~

~~(a) Premiums.~~

~~(1) (A) The Arkansas Comprehensive Health Insurance Pool shall establish premium rates for plan coverage as provided in subdivision (a)(2)~~

~~of this section.~~

~~(B) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.~~

~~(C) Premium rates and schedules shall be submitted to the Insurance Commissioner for approval prior to use.~~

~~(2)(A)(i) With the assistance of the commissioner, the pool shall determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals in Arkansas.~~

~~(ii) The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage.~~

~~(B)(i) Rates for plan coverage shall not exceed one hundred fifty percent (150%) of rates established as applicable for individual standard risks in Arkansas.~~

~~(ii) Subject to the limits provided in this subdivision (a)(2), subsequent rates shall be established to help provide for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this section.~~

~~(b) Sources of Additional Revenue.~~

~~(1) In addition to the powers enumerated in § 23-79-506, the pool shall have the authority to:~~

~~(A) Assess insurers in accordance with the provisions of this section; and~~

~~(B)(i) Make advance interim assessments as may be reasonable and necessary for the pool's organizational and interim operating expenses.~~

~~(ii) Any such interim assessments may be credited as offsets against any regular assessments due following the close of the fiscal year.~~

~~(2)(A) Following the close of each fiscal year, the plan administrator shall determine the net premiums, that is, premiums less administrative expense allowances, the pool expenses of administration and operation, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.~~

~~(B) The deficit incurred by the pool not otherwise recouped under either subdivision (b)(9) of this section or subsection (c) of this section [repealed], or both, shall be recouped by assessments apportioned among insurers by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool.~~

~~(3) Each insurer's assessment shall be determined by multiplying the total assessment of all insurers as determined in subdivision (b)(2) of this section by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all health insurance premiums by all insurers.~~

~~(4)(A) If assessments or other funds received under either subdivision (b)(9) of this section or subsection (c) of this section [repealed], or both, or any combination of the assessments and funds exceed the pool's actual losses and administrative expenses, the excess shall be held at interest and used by the board to offset future losses or to reduce future assessments.~~

~~(B) As used in this subsection, "future losses" includes reserves for incurred but not reported claims.~~

~~(5) Each insurer's assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board or the commissioner.~~

~~(6)(A)(i) An insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board.~~

~~(ii) The commissioner may abate or defer, in whole or in part, the assessment if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations.~~

~~(B)(i) In the event an assessment against an insurer is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred shall be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this subsection.~~

~~(ii) The insurer receiving the abatement or deferment shall remain liable to the plan for the deficiency for four (4) years.~~

~~(7) For all assessments issued by the board, beginning January~~

~~1, 1998, only those individuals, corporations, associations, or other entities defined as an insurer in § 23-79-503 shall be subject to assessment.~~

~~(8) In the event the board fails to act within a reasonable period of time to recoup by assessment any deficit incurred by the pool, the commissioner shall have all the powers and duties of the board under this chapter with respect to assessing insurers.~~

~~(9) The General Assembly further intends that the pool be eligible for, and for the pool, its board, or other officers of state government, as appropriate, to take steps necessary to obtain federal grant funds to offset losses of the pool, including any funds made available under the Trade Adjustment Assistance Reform Act of 2002.~~

~~(c) Assessment Offsets.~~

~~(1) Any assessment may be offset in an amount equal to the amount of the assessment paid to the pool against the premium tax payable by that insurer for the year in which the assessment is levied or for the four (4) years subsequent to that year.~~

~~(2) No offset shall be allowed for any penalty assessed under subdivision (d)(1) of this section.~~

~~(d)(1) All assessments and fees shall be due and payable upon receipt and shall be delinquent if not paid within thirty (30) days of the receipt of the notice by the insurer.~~

~~(2) Failure to timely pay the assessment will automatically subject the insurer to a ten percent (10%) penalty, which will be due and payable within the next thirty-day period.~~

~~(3) The board and the commissioner shall have the authority to enforce the collection of the assessment and penalty in accordance with the provisions of this subchapter and the Arkansas Insurance Code.~~

~~(4) The board may waive the penalty authorized by this subsection if it determines that compelling circumstances exist that justify such a waiver.~~

~~23-79-508. Plan administrator.~~

~~(a) The Board of Directors of the Arkansas Comprehensive Health Insurance Pool shall select an insurer through a competitive bidding process to administer the plan. However, the administering insurer designated by the board created by Acts 1995, No. 1339, shall serve as the plan administrator~~

~~under this subchapter until the expiration of the current contract of the administering insurer. The board shall evaluate bids submitted under this section based upon criteria established by the board which shall include, but not be limited to, the following:~~

~~(1) The plan administrator's proven ability to handle large group accident and health benefit plans;~~

~~(2) The efficiency and timeliness of the plan administrator's claim processing procedures;~~

~~(3) An estimate of total charges for administering the plan;~~

~~(4) The plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost efficient manner; and~~

~~(5) The financial condition and stability of the plan administrator.~~

~~(b)(1) The plan administrator shall serve for a period of three (3) years subject to removal for cause and subject to the terms, conditions, and limitations of the contract between the board and the plan administrator.~~

~~(2) The board shall advertise for and accept bids to serve as the plan administrator for the succeeding three-year periods.~~

~~(c) The plan administrator shall perform functions related to the plan as may be assigned to it, including:~~

~~(1) Determination of eligibility;~~

~~(2) Payment and processing of claims;~~

~~(3) Establishment of a premium billing procedure for collection of premiums. Billings shall be made on a periodic basis as determined by the board; and~~

~~(4) Other necessary functions to assure timely payment of benefits to covered persons under the plan, including:~~

~~(A) Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made; and~~

~~(B) Evaluating the eligibility of each claim for payment under the plan.~~

~~(d)(1) The plan administrator shall submit regular reports to the board regarding the operation of the plan.~~

~~(2) Frequency, content, and form of the report shall be~~

~~determined by the board.~~

~~(e)(1) The plan administrator shall pay claim expenses from the premium payments received from or on behalf of plan participants and allocated by the board for claim expenses.~~

~~(2) If the plan administrator's payments for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide additional funds to the plan administrator for payment of claims expenses.~~

~~(f) The plan administrator shall be governed by the requirements of this subchapter and shall be compensated as provided in the contract between the board and the plan administrator.~~

~~23-79-509. Plan eligibility.~~

~~(a) General Eligibility Requirements. The following requirements apply to a resident eligible person or a trade adjustment assistance eligible person in order for the person to be eligible for plan coverage:~~

~~(1) Except as provided in subdivision (a)(2) of this section or subsection (b) of this section, any individual person who meets the definition of resident eligible person as defined by § 23-79-503 or a trade adjustment assistance eligible person as defined by § 23-79-503 and is either a citizen of the United States or an alien lawfully admitted for permanent residence who continues to be a resident of this state shall be eligible for plan coverage if evidence is provided of:~~

~~(A) A notice of rejection or refusal by an insurer to issue substantially similar individual health insurance coverage by reason of the existence or history of a medical condition or upon such other evidence that the Board of Directors of the Arkansas Comprehensive Health Insurance Pool deems sufficient in order to verify that the applicant is unable to obtain the coverage from an insurer due to the existence or history of a medical condition;~~

~~(B)(i) A refusal by an insurer to issue individual health insurance coverage except at a rate that the board determines is substantially in excess of the applicable plan rate.~~

~~(ii) A rejection or refusal by a group health plan or insurer offering only stop-loss or excess-of-loss insurance or contracts, agreements, or other arrangements for reinsurance coverage with respect to~~

~~the applicant shall not be sufficient evidence under this subsection;~~

~~(C)(i) Until September 30, 2011, a refusal by an insurer to issue individual health insurance coverage to a child under nineteen (19) years of age.~~

~~(ii) After September 30, 2011, the eligibility of a child under nineteen (19) years of age for individual health insurance coverage shall be determined by the board; or~~

~~(D) Evidence that the applicant was covered under a qualified high-risk pool of another state, provided that the coverage terminated no more than sixty-three (63) days prior to the date the pool receives the applicant's application for coverage and the other state's qualified high-risk pool did not terminate the person's coverage for fraud;~~

~~(2) A person shall not be eligible for coverage under the plan if:~~

~~(A) The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy or would be eligible to have coverage if the person elected to obtain it except that:~~

~~(i) A person may maintain other coverage for the period of time the person is satisfying any waiting period for a preexisting condition under a plan policy; and~~

~~(ii) A person may maintain plan coverage for the period of time the person is satisfying a waiting period for a preexisting condition under another health insurance policy intended to replace the plan policy;~~

~~(B) The person is determined to be eligible for healthcare benefits under Title XIX of the Social Security Act;~~

~~(C) The person has previously terminated plan coverage unless twelve (12) months have elapsed since termination of coverage;~~

~~(D) The person fails to pay the required premium under the covered person's terms of enrollment and participation, in which event the liability of the plan shall be limited to benefits incurred under the plan for the same period for which premiums had been paid and the covered person remained eligible for plan coverage;~~

~~(E) The plan has paid on behalf of the covered person the maximum lifetime benefit established by the board in accordance with § 23-79-510(a)(2)(W);~~

~~(F) The person is a resident of a public institution;~~

~~(G) All or part of the person's premium is paid for or reimbursed:~~

~~(i) By one (1) of the following in connection with a group health plan:~~

~~(a) The person's current employer;~~

~~(b) If the person is retired, by the person's former employer; or~~

~~(c) If the person is a dependent of an employee or retiree, by the current or former employer of the employee or retiree; or~~

~~(ii) Under any government-sponsored program or by any government agency, foundation, healthcare facility, or healthcare provider except for premiums paid on behalf of:~~

~~(a) A trade adjustment assistance eligible person or a qualified trade adjustment assistance eligible person in accordance with section 35 of the Internal Revenue Code; or~~

~~(b) An otherwise qualifying full-time employee or dependent of a qualifying full-time employee of a government agency, foundation, healthcare facility, or healthcare provider; or~~

~~(H) The person commits a fraudulent insurance act as defined in § 23-66-501(4) against the Arkansas Comprehensive Health Insurance Pool;~~

~~(3) The board or the plan administrator shall require verification of residency and may require any additional information, documentation, or statements under oath whenever necessary to determine plan eligibility or residency;~~

~~(4) Coverage shall cease:~~

~~(A) On the date a person is no longer a resident of the State of Arkansas;~~

~~(B) On the date a person requests coverage to end;~~

~~(C) On the death of the covered person;~~

~~(D) On the date state law requires cancellation of the policy; or~~

~~(E) At the plan's option, thirty (30) days after the plan makes any written inquiry concerning a person's eligibility or place of~~

~~residence to which the person does not reply; and~~

~~(5) Except under the conditions set forth in subdivision (a)(4) of this section, the coverage of any person who ceases to meet the eligibility requirements of this section terminates at the end of the month that the person ceases to meet the eligibility requirements of this section.~~

~~(b) Persons Eligible for Guaranteed Issuance of Coverage. The following requirements apply to a federally eligible individual or a qualified trade adjustment assistance eligible person in order for such an individual to be eligible for plan coverage:~~

~~(1) Notwithstanding the requirements of subsection (a) of this section, any federally eligible individual or a qualified trade adjustment assistance eligible person for whom a plan application and such enclosures and supporting documentation as the board may require is received by the board within sixty-three (63) days after the termination of prior creditable coverage for reasons other than nonpayment of premium or fraud that covered the applicant shall qualify to enroll in the plan under the portability provisions of this subsection;~~

~~(2) Any individual seeking plan coverage under this subsection must submit with his or her application evidence, including acceptable written certification of previous creditable coverage, that will establish to the board's satisfaction that he or she meets all of the requirements to be a federally eligible individual or a qualified trade adjustment assistance eligible person and is currently and permanently residing in the State of Arkansas as of the date his or her application was received by the board;~~

~~(3) A period of creditable coverage shall not be counted, with respect to qualifying an applicant for plan coverage as an individual under this subsection, if after such a period and before the application for plan coverage was received by the board, there was at least a sixty-three-day period during all of which the individual was not covered under any creditable coverage;~~

~~(4) Any individual who the board determines qualifies for plan coverage under this subsection shall be offered his or her choice of enrolling in one (1) of the alternative portability plans that the board is authorized under this subsection to establish for those individuals;~~

~~(5)(A)(i) The board shall offer a choice of healthcare coverages consistent with major medical coverage under the alternative plans authorized~~

~~by this subsection to every individual qualifying for coverage under this subsection.~~

~~(ii) The coverages to be offered under the plans, the schedule of benefits, deductibles, copayments, coinsurance, exclusions, and other limitations shall be approved by the board.~~

~~(B) One (1) optional form of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in the State of Arkansas or a standard option of coverage available under the individual health insurance laws of the State of Arkansas. The standard plan that is authorized by § 23-79-510 may be used for this purpose.~~

~~(C) The board also may offer a preferred provider option and such other options as the board determines may be appropriate for individuals who qualify for plan coverage pursuant to this subsection;~~

~~(6) Notwithstanding the requirements of § 23-79-510(f), any plan coverage that is issued to individuals who qualify for plan coverage pursuant to the portability provisions of this subsection shall not be subject to any preexisting conditions exclusion, waiting period, or other similar limitation on coverage;~~

~~(7) Individuals who qualify and enroll in the plan pursuant to this subsection shall be required to pay such premium rates as the board shall establish and approve in accordance with the requirements of § 23-79-507(a);~~

~~(8) The total premium, without regard to any subsidy of premium, for individuals who qualify and enroll in the plan pursuant to this subsection shall not be greater than a similarly situated individual qualifying for pool coverage under subsection (a) of this section; and~~

~~(9) A federally eligible individual who qualifies and enrolls in the plan pursuant to this subsection must continue to satisfy all of the other eligibility requirements of this subchapter to the extent not inconsistent with the Health Insurance Portability and Accountability Act of 1996 in order to maintain continued eligibility for coverage under the plan.~~

~~(c) Any person who was issued a policy pursuant to the provisions of Acts 1995, No. 1339, shall be deemed continuously covered consistent with the terms of this subchapter and reissued a new policy in accordance with the provisions of this subchapter.~~

~~23-79-510. Outline of benefits.~~

~~(a)(1) Subject to the contractual policy form language adopted by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool, expenses for the following services, supplies, drugs, or articles when prescribed by a physician and determined by the plan to be medically necessary shall be covered, subject to provisions of subsection (b) of this section:~~

~~(A) Hospital services;~~

~~(B) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician or by other licensed professionals at his or her direction;~~

~~(C) Drugs requiring a physician's prescription;~~

~~(D) Skilled nursing services of a licensed skilled nursing facility for not more than one hundred twenty (120) days during a policy year;~~

~~(E) Services of a home health agency up to a maximum of two hundred seventy (270) services per year;~~

~~(F) Use of radium or other radioactive materials;~~

~~(G) Oxygen;~~

~~(H) Prostheses other than dental;~~

~~(I) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which such equipment is prescribed;~~

~~(J) Diagnostic X rays and laboratory tests;~~

~~(K) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;~~

~~(L) Services of a physical therapist;~~

~~(M) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest facility qualified to treat a covered condition;~~

~~(N) Services for diagnosis and treatment of mental and nervous disorders or chemical and drug dependency, provided that a covered person shall be required to make a fifty percent (50%) copayment and that the plan's payment shall not exceed four thousand dollars ($4,000) annually; and~~

~~(O) Such additional benefits deemed appropriate by the board in accordance with the provisions of subsection (b) of this section.~~

~~(2) Exclusions. Unless the contractual policy form language adopted by the board provides otherwise, the following services, supplies, drugs, or articles whether or not prescribed by a physician, shall not be covered:~~

~~(A) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;~~

~~(B) Care that is primarily for custodial or domiciliary purposes;~~

~~(C) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room unless a private room is medically necessary;~~

~~(D) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other healthcare personnel that exceeds the prevailing charge in the locality or for any charge not medically necessary;~~

~~(E) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;~~

~~(F) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred;~~

~~(G) Dental care except as provided in subdivision (a)(1)(K) of this section;~~

~~(H) Eyeglasses and hearing aids;~~

~~(I) Illness or injury due to acts of war;~~

~~(J) Services of blood donors and any fee for failure to replace the first three (3) pints of blood provided to a covered person each policy year;~~

~~(K) Personal supplies or services provided by a hospital or nursing home or any other nonmedical or nonprescribed supply or service;~~

~~(L) Any expense or charge for services, articles, drugs, or supplies that are not provided in accord with generally accepted standards of current medical practice;~~

~~(M) Any expense for which a charge is not made in the~~

~~absence of insurance or for which there is no legal obligation on the part of the patient to pay;~~

~~(N) Any expense incurred for benefits provided under the laws of the United States and the State of Arkansas, including Medicare and Medicaid and other medical assistance, military service-connected disability payments, medical services provided for members of the armed forces and their dependents or employees of the United States Armed Forces, and medical services financed on behalf of all citizens by the United States;~~

~~(O) Any expense or charge for in vitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy;~~

~~(P) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures;~~

~~(Q) Any expense or charge for sterilization or sterilization reversals;~~

~~(R) Any expense or charge for weight-loss programs, exercise equipment, or treatment of obesity except when certified by a physician as morbid obesity, i.e., at least two (2) times normal body weight;~~

~~(S) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery;~~

~~(T) Any expense or charge for organ or bone marrow transplants other than those performed at a hospital with a board-approved organ transplant program that has been designated by the board as a preferred provider organization for that specific organ or bone marrow transplant;~~

~~(U) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical specialty college for general use within the medical community;~~

~~(V) Such additional exclusions deemed appropriate by the board in accordance with the provisions of subsection (b) of this section; and~~

~~(W)(i) Any benefits that exceed the maximum lifetime benefit for plan coverage established by the board under § 23-79-506(a)(1)(N).~~

~~(ii) The maximum lifetime benefit shall not be less than one million dollars ($1,000,000) and shall not exceed three million dollars ($3,000,000).~~

~~(b) In establishing the plan coverage, the board shall take into consideration the levels of health insurance provided in the state and medical economic factors as may be deemed appropriate and promulgate benefits, deductibles, copayments, coinsurance factors, exclusions, and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.~~

~~(c) The board may adjust any deductibles, copayments, and coinsurance factors annually according to the medical component of the Consumer Price Index for All Urban Consumers.~~

~~(d) Nonduplication of Benefits.~~

~~(1)(A) The pool shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available.~~

~~(B) Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance or any other source providing benefits because of a sickness or injury and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance whether provided on the basis of fault or nonfault and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.~~

~~(2) The pool shall have a cause of action against a covered person for the recovery of the amount of benefits paid that are not covered by the pool. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this subdivision (d)(2).~~

~~(e) Right of Subrogation — Recoveries.~~

~~(1)(A) Whenever the pool has paid benefits because of sickness or an injury to any covered person resulting from a third party's wrongful act or negligence or for which an insurance company or self-insured entity is liable in accordance with the provisions of any policy of insurance, and the covered person has recovered or may recover damages from a third party that is liable for damages, the pool shall have the right to recover the benefits it paid from any amounts that the covered person has received or may receive~~

~~regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from the sickness or injury.~~

~~(B) The pool shall be subrogated to any right of recovery the covered person may have under the terms of any private or public healthcare coverage or liability coverage including coverage under a workers' compensation act without the necessity of assignment of claim or other authorization to secure the right of recovery.~~

~~(C) To enforce its subrogation right, the pool may:~~

~~(i) Intervene or join in an action or proceeding brought by the covered person or his or her personal representative, including his or her guardian, conservator, estate, dependents, or survivors, against any third party or the third party's insurance carrier or self-insured entity that may be liable; or~~

~~(ii) Institute and prosecute legal proceedings against any third party or the third party's insurance carrier or self-insured entity that may be liable for the sickness or injury in an appropriate court either in the name of the pool or in the name of the covered person or his or her personal representative including his or her guardian, conservator, estate, dependents, or survivors.~~

~~(2)(A)(i) If any action or claim is brought by or on behalf of a covered person against a third party or the third party's insurance carrier or self-insured entity, the covered person or his or her personal representative, including his or her guardian, conservator, estate, dependents, or survivors, shall notify the pool by personal service or registered mail of the action or claim and of the name of the court in which the action or claim is brought, filing proof thereof in the action or claim.~~

~~(ii) The pool may, at any time thereafter, join in the action or claim upon its motion so that all orders of court after hearing and judgment shall be made for its protection.~~

~~(B) No release or settlement of a claim for damages and no satisfaction of judgment in the action shall be valid without the written consent of the pool to the extent of its interest in the settlement or judgment and of the covered person or his or her personal representative.~~

~~(3)(A) In the event that the covered person or his or her personal representative fails to institute a proceeding against any appropriate third party before the fifth month before the action would be~~

~~barred, the pool, in its own name or in the name of the covered person or personal representative, may commence a proceeding against any appropriate third party for the recovery of damages on account of any sickness, injury, or death to the covered person.~~

~~(B) The covered person shall cooperate in doing what is reasonably necessary to assist the pool in any recovery and shall not take any action that would prejudice the pool's right to recovery.~~

~~(C) The pool shall pay to the covered person or his or her personal representative all sums collected from any third party by judgment or otherwise in excess of amounts paid in benefits under the pool and amounts paid or to be paid as costs, attorney's fees, and reasonable expenses incurred by the pool in making the collection or enforcing the judgment.~~

~~(4)(A)(i) In the event of judgment or award in either a suit or claim against a third party, the court shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees.~~

~~(ii) After payment of those expenses and attorney's fees, the court shall apply out of the balance of the judgment or award an amount sufficient to reimburse the pool the full amount of benefits paid on behalf of the covered person under this subchapter, provided that the court may reduce and apportion the pool's portion of the judgment proportionately to the recovery of the covered person.~~

~~(B)(i) The burden of producing sufficient evidence to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking the reduction.~~

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

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

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

~~State of Arkansas.~~

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

~~(f) Preexisting Conditions.~~

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

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

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

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

~~(A) Has satisfied similar exclusions under any prior individual health insurance coverage that was involuntarily terminated; and~~

~~(B)(i) Has applied for plan coverage not later than thirty (30) days following the involuntary termination.~~

~~(ii) For each resident eligible person or trade adjustment assistance eligible person who qualifies for and elects this waiver, there shall be added on a prorated basis to each payment of premium a surcharge of up to ten percent (10%) of the otherwise applicable annual premium for as long as that individual's coverage under the plan remains in effect or sixty (60) months, whichever is less.~~

~~(3)(A) Whenever benefits are due from the plan because of sickness or an injury to a covered person resulting from a third party's wrongful act or negligence and the covered person has recovered or may~~

~~recover damages from a third party or its insurance carrier or self-insured entity, the plan shall have the right to reduce benefits or to refuse to pay benefits that otherwise may be payable in the amount of damages that the covered person has recovered or may recover regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury.~~

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

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

~~(C) Any amounts due the plan to repay benefits may be deducted from other benefits payable by the plan after payments by or for the third party are made.~~

~~(4) Benefits due from the plan may be reduced or refused as an offset against any amount otherwise recoverable under this section.~~

~~23-79-511. Confidentiality.~~

~~(a)(1) All steps necessary under state and federal law to protect confidentiality of applicants and covered persons shall be undertaken by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool to prevent the identification of individual records of covered persons under the plan, rejected by the plan, or who may become ineligible for further participation in the plan.~~

~~(2) Procedures shall be written by the board to assure the confidentiality of records of persons covered under, rejected by, or who became ineligible for further participation in the plan when gathering and submitting data to the board or any other entity.~~

~~(b) Any information submitted to the board by hospitals or any other~~

~~provider pursuant to this subchapter from which the identity of a particular individual can be determined shall be privileged and confidential and shall not be disclosed in any manner. The foregoing includes, but shall not be limited to, disclosure, inspection, or copying under the Freedom of Information Act of 1967, § 25-19-101 et seq.~~

~~23-79-512. Collective action.~~

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

~~23-79-513. Unfair referral to plan — Prohibited practices by employers.~~

~~(a) It shall constitute an unfair trade practice under the Trade Practices Act, § 23-66-201 et seq., for an insurer, agent, broker, or third-party administrator to refer an individual to the Arkansas Comprehensive Health Insurance Pool or arrange for an individual to apply to the pool for the purpose of:~~

~~(1) Separating the individual from group health insurance coverage provided by a group health plan; or~~

~~(2) Facilitating enrollment in the pool by any of the following individuals associated with an employer, with the knowledge that the employer intends to pay or is paying all or part of the premium payments owed by the individual for pool coverage:~~

~~(A) An employee of the employer;~~

~~(B) A retired employee of the employer; or~~

~~(C) A dependent of an employee or retired employee of the employer.~~

~~(b) Because pool coverage is not intended to cover participants who are eligible for a group health plan, an individual described in subdivision (a)(2) of this section is not eligible:~~

~~(1) For pool coverage if the employer associated with the applicant intends to pay for all or part of the pool premium payments for the individual; or~~

~~(2) To continue pool coverage if the employer associated with~~

~~the individual directly or indirectly pays all or part of the pool premium payments for the individual.~~

~~23-79-514. [Repealed.]~~

~~23-79-515. Orderly cessation of operations.~~

~~(a)(1) The Arkansas Comprehensive Health Insurance Pool shall cease enrollment and coverage under the plan on and after January 1, 2014, as required by federal law.~~

~~(2) After taking all reasonable steps, including those specified in this section, to timely and efficiently assist in the transition of individuals receiving plan coverage to the individual health insurance market, the Board of Directors of the Arkansas Comprehensive Health Insurance Pool shall cease operating the pool after paying health insurance claims for plan coverage and meeting all other obligations of the board under this section.~~

~~(b) The board may take all actions it deems necessary to:~~

~~(1) Cease enrollment for plan coverage effective December 1, 2013;~~

~~(2)(A) Terminate all existing plan coverage effective at the end of the calendar day on December 31, 2013.~~

~~(B) The board shall provide at least ninety (90) days notice to current policyholders of the termination; and~~

~~(3) Amend plan policies and provide adequate notice to policyholders, agents, and providers that to be paid or reimbursed, a claim for plan services is required to be filed by the earlier of one hundred eighty (180) days after plan coverage ends or three hundred sixty-five (365) days after the date of service giving rise to the claim.~~

~~(c) This section does not require the board to revise plan benefits to comply with federal law or to maintain plan coverage for any individual after December 31, 2013.~~

~~(d)(1) After all plan coverage terminates under this section, the board shall take reasonable steps to wind up all significant operations of the pool by December 31, 2014.~~

~~(2) Notwithstanding any other provision of this subchapter, to facilitate an efficient cessation of operations:~~

~~(A) The board may continue to use existing contractors until cessation of operations without the need to issue competitive requests for proposals;~~

~~(B) The board may continue to fund operations of this subchapter under § 23-79-507;~~

~~(C) The board shall remain in effect:~~

~~(i) As provided by § 23-79-504(b); and~~

~~(ii) Until a judgment, order, or decree in any action, suit, or proceeding commenced against or by the pool is fully executed; and~~

~~(D)(i) The term of each current board member shall be extended until the date the pool concludes all business as provided under this section and the Insurance Commissioner certifies the cessations of operations under subsection (g) of this section.~~

~~(ii) The term of a board member expires when the commissioner certifies the cessations of operations under subsection (g) of this section.~~

~~(e) On or before June 30, 2013, the board shall amend the plan of operation to reflect the actions necessary to implement this section.~~

~~(f) If the board has excess funds after the cessation of operations of the pool, the funds shall be returned to the general revenue funds of the state.~~

~~(g)(1) On or before March 1, 2016, or a later date if necessary to complete the cessation of operations of the pool, the board shall file a report with the General Assembly and commissioner that reflects completion of the requirements of this section and includes an independent auditor's report on the financial statements of the pool.~~

~~(2) If satisfied upon review of the report that the board has complied with this section and accomplished the pool's cessation of operations in a reasonable manner, the commissioner shall certify that the business of the pool has concluded in accordance with this section and publish the certification on the State Insurance Department website.~~

~~(h) Upon certification under subsection (g) of this section, the operations of the pool are suspended indefinitely unless reactivated by the General Assembly.~~

~~(i) The commissioner may address any matters regarding the pool~~

~~arising after the certification under subsection (g) of this section, and the Attorney General shall defend a legal action filed after the certification, including seeking the dismissal of the action under § 23-79-516 or for any other purpose.~~

~~(j) Unless inconsistent with this section, the remainder of this subchapter continues to apply to the pool and the board.~~

~~23-79-516. Statute of limitations and repose.~~

~~Because winding up the operations of the Arkansas Comprehensive Health Insurance Pool requires the expeditious determination of its outstanding liabilities, a cause of action against the pool or the Board of Directors of the Arkansas Comprehensive Health Insurance Pool shall be commenced within the earlier of one (1) year after the cause of action accrues or December 31, 2015.~~

~~23-79-517. Individuals moving to Arkansas and previously covered by another qualified high-risk pool.~~

~~(a) Notwithstanding § 23-79-510(f), if a resident eligible person is eligible for plan coverage because the person previously was covered under a qualified high-risk pool of another state, a preexisting condition exclusion otherwise applicable to the resident eligible person:~~

~~(1) Shall be reduced by each month of coverage in which the resident eligible person was subject to a preexisting condition exclusion in the other state's qualified high-risk pool; or~~

~~(2) Does not apply if the resident eligible person was not subject to a preexisting condition exclusion in the other state's qualified high-risk pool.~~

~~(b) This section expires on the last day an individual may be enrolled into plan coverage under this subchapter.~~

SECTION 6. Arkansas Code § 23-86-113 is repealed.

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

~~(a) Unless refused in writing, every group accident and health insurance 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 Aging, Adult, and Behavioral 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 or a community mental health center certified by the division 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;~~

~~(B) A physician licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 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 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 that the 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 that 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, a hospital and medical service corporation, a healthcare plan, a 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.~~

SECTION 7. Arkansas Code § 23-99-502 is amended to read as follows:

23-99-502. Legislative findings and intent.

It is the intent of this state that if a health benefit plan provides insurance coverage for a mental ~~illness or substance abuse~~ health and substance use disorder, ~~the treatment of the mental illness or substance abuse disorder~~ the benefits shall be as available as and at parity with ~~that for other medical illnesses~~ other medical and surgical benefits.

SECTION 8. Arkansas Code § 23-99-503 is amended to read as follows:

23-99-503. Definitions.

As used in this subchapter:

(1) "Carve-out arrangement" means an arrangement in which a healthcare insurer contracts with a separate person or entity to arrange for

the delivery of specific types of healthcare benefits under a health benefit plan;

~~(2) "Commissioner" means the Insurance Commissioner;~~

~~(3)~~(2)(A) "Financial requirements" means copayments, deductibles, out-of-network charges, out-of-pocket contributions or fees, ~~annual limits, lifetime aggregate limits imposed on individual patients,~~ and other patient cost-sharing amounts.

(B) "Financial requirements" does not include aggregate lifetime or annual dollar limits;

~~(4)~~(3) "Health benefit plan" means any individual, group, or blanket plan, policy, or contract for healthcare services issued or delivered in this state by healthcare insurers, including indemnity and managed care plans and the plans providing health benefits to state and public school employees pursuant to § 21-5-401 et seq., but excluding plans providing ~~health care~~ healthcare services pursuant to Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

~~(5)~~(4) "Healthcare insurer" means any insurance company, hospital and medical service corporation, or health maintenance organization issuing or delivering health benefit plans in this state and subject to any of the following laws:

(A) The Arkansas Insurance Code;

(B) Section 23-75-101 et seq., pertaining to hospital and medical service corporations;

(C) Section 23-76-101 et seq., pertaining to health maintenance organizations; and

(D) Any successor law of the foregoing;

~~(6)(A)~~(5)(A) ~~"Mental illnesses" and "substance use disorders" mean those illnesses and disorders that are covered by a health benefit plan listed in the International Classification of Diseases manual and the Diagnostic and Statistical Manual of Mental Disorders~~ "Mental health benefits" means benefits with respect to items or services for mental health conditions, as defined under the terms of the health benefit plan or health insurance coverage and according to applicable federal and state law.

(B) ~~Unless specifically otherwise stated, "mental illness" includes substance use disorders~~ "Mental health benefits" that are defined by

a health benefit plan or health insurance coverage as being or not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice, including conditions that are listed in the Diagnostic and Statistical Manual of Mental Disorders, the International Classification of Diseases, or state guidelines;

~~(7)~~(6) "Person" or "entity" means ~~and includes~~, individually and collectively, any individual, corporation, partnership, firm, trust, association, voluntary organization, or any other form of business enterprise or legal entity; and

~~(8)~~(7)(A) ~~"Small employer" means any person or entity actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no more than fifty (50) eligible employees~~ "Substance abuse disorder benefits" means benefits with respect to items or services for substance use disorders, as defined under the terms of the health benefit plan or health insurance coverage and according to applicable federal and state law.

(B) "Substance abuse disorder benefits" that are defined by a health benefit plan or health insurance coverage as being or not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice, including conditions that are listed in the Diagnostic and Statistical Manual of Mental Disorders, the International Classification of Diseases, or state guidelines.

SECTION 9. Arkansas Code § 23-99-504 is amended to read as follows:

23-99-504. Exclusions.

This subchapter does not apply to:

(1) Dental insurance plans;

(2) Vision insurance plans;

(3) Specified-disease insurance plans;

(4) Accidental injury insurance plans;

(5) Long-term care plans;

(6) Disability income plans; and

(7) ~~Individual health benefit plans if the healthcare insurers offer individuals who satisfy the healthcare insurer's underwriting standards the option of purchasing a plan that, other than being optional, meets all the other requirements of this subchapter;~~

~~(8) Health benefit plans for small employers if the healthcare insurers offer purchasers the option of purchasing a plan that, other than being optional, meets all the other requirements of this subchapter; and~~

~~(9)~~ Medicare supplement plans, as subject to section 1882(g)(1) of the Social Security Act.

SECTION 10. Arkansas Code § 23-99-505 is amended to read as follows:

23-99-505. Increased cost exemption.

(a)(1) This subchapter does not apply to a health benefit plan during the health benefit plan's following health benefit plan year if the application of this subchapter to the health benefit plan in a health benefit plan year resulted in an increase in the actual costs of coverage with respect to medical and surgical benefits and mental ~~illness~~ health benefits and substance abuse disorder benefits under the health benefit plan as determined and certified under subsection (b) of this section by an amount that exceeds:

(A) Two percent (2%) for the first health benefit plan year in which this section is applied; or

(B) One percent (1%) for each subsequent health benefit plan year.

(2) The exemption provided by subdivision (a)(1) of this section applies to a health benefit plan for one (1) year.

(3) A healthcare insurer may elect to continue to apply mental health parity under this subchapter to its health benefit plans regardless of any increase in its total costs of coverage.

(b)(1) A determination under this section of increases to the actual costs of coverage of a health benefit plan shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries.

(2) The determination shall be in a written report prepared by the actuary.

(3) The report and all underlying documentation relied upon by the actuary shall be maintained by the healthcare insurer for a period of six (6) years following the notification required by subsection (d) of this section.

(c) To obtain an exemption under this section, a healthcare insurer

shall make the increased cost determination required by this section after the health benefit plan has complied with this section for the first six (6) months of the health benefit plan year.

(d)(1) A healthcare insurer that elects to claim an exemption for a ~~qualifying~~ health benefit plan under this section based upon a certification under subsection (b) of this section shall promptly notify the Insurance Commissioner, the policyholder or contract holder, and the certificate holders, subscribers, and enrollees covered by the health benefit plan of its election.

(2)(A) The notification to the commissioner under subdivision (d)(1) of this section shall include:

~~(A)~~(i) A description of the number of covered lives under the health benefit plan at the time of the notification and, if applicable, at the time of any prior election of the increased cost exemption under this section; and

~~(B)~~(ii) For the current and previous health benefit plan year:

~~(i)~~(a) A description of the actual total costs of coverage for medical and surgical benefits and mental ~~illness~~ health and substance use benefits under the health benefit plan; and

~~(ii)~~(b) The actual total costs of coverage with respect to mental illness benefits under the health benefit plan.

~~(3)(A) A notification under this subsection is confidential.~~

(B) The commissioner shall make available upon request, but not more than annually, an anonymous itemization of notifications under this section that includes a summary of the data received under this subdivision (d)(2) ~~of this section~~.

(3) The notification to the policyholder or contract holder and certificate holders, subscribers, and enrollees shall comply with the requirements of 45 C.F.R. § 146.136(g)(6)(i), as it existed on May 23, 2024.

(4) A notification provided under this subsection is confidential.

(e) To determine compliance with this section, the commissioner may audit the books and records of a healthcare insurer relating to an exemption, including without limitation any actuarial reports prepared pursuant to

subsection (b) of this section during the six-year period following the notification required by subsection (d) of this section.

(f) The commissioner may promulgate rules to implement this section.

SECTION 11. Arkansas Code § 23-99-506 is amended to read as follows:

23-99-506. Parity requirements.

(a) Except as provided in § 23-99-504, if a health benefit plan that provides ~~benefits for the diagnosis and treatment of mental illnesses shall provide the benefits under the same terms and conditions as provided for covered benefits offered under the health benefit plan for the treatment of other medical illnesses and conditions, including without limitation:~~

~~(1) The duration or frequency of coverage;~~

~~(2) The dollar amount of coverage; or~~

~~(3) Financial requirements~~ insurance coverage for mental health and substance use, the benefits shall be as available as and at parity with other medical and surgical benefits.

(b) Except as provided under this section, a health carrier that offers or issues individual or group health benefit plans that are delivered, issued for delivery, continued, or renewed in this state and that provide coverage for mental health and substance use shall comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. Section 300gg-26, as it existed on January 1, 2025, and the federal regulations promulgated thereunder.

(c) This subchapter does not:

(1) Require equal coverage between ~~treatments for a mental illness with~~ mental health and substance use benefits and coverage for preventive care benefits;

(2) Prohibit a healthcare insurer from:

(A) Negotiating separate reimbursement rates and service delivery systems, including without limitation a carve-out arrangement; or

(B) ~~Managing the provision of mental health benefits for mental illnesses by common methods used for other medical conditions, including without limitation preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage of services or mental illnesses to mental illnesses that are deemed medically necessary;~~

~~(C)~~ Limiting covered services to covered services

authorized by the health benefit plan, if the limitations are made in accordance with this subchapter and federal law;

~~(D) Using separate but equal cost-sharing features for mental illnesses; or~~

~~(E) Using a single lifetime or annual dollar limit as applicable to other medical illness;~~ and

(3) Include a Medicare or Medicaid plan or contract or any privatized risk or demonstration program for Medicare or Medicaid coverage.

SECTION 12. Arkansas Code § 23-99-507 is amended to read as follows:

23-99-507. Medical necessity.

(a) The criteria for medical necessity determinations for mental ~~illness~~ health benefits and substance abuse disorder benefits made under a health benefit plan shall be made available by the healthcare insurer ~~in accordance with~~ according to rules established by the Insurance Commissioner to any current or potential covered individual or contracting provider upon request.

(b) On request, the reason for a denial of reimbursement or payment for services ~~to diagnose or treat mental illness~~ with respect to mental health benefits or substance abuse disorder benefits under a health benefit plan shall be made available by the healthcare insurer to a covered individual ~~in accordance with~~ according to the rules of the commissioner.

SECTION 13. Arkansas Code § 23-99-508 is repealed.

~~23-99-508. Permitted provisions.~~

~~(a) A healthcare insurer may at the healthcare insurer's option provide coverage for a health service, such as intensive case management, community residential treatment programs, or social rehabilitation programs, that is used in the treatment of mental illnesses but is generally not used for other injuries, illnesses, and conditions if the other requirements of this subchapter are met.~~

~~(b) Healthcare insurers providing educational remediation may, but are not required to, comply with the terms of this subchapter in regard to the treatment or remediation.~~

~~(c) A healthcare insurer may provide coverage for a health service, including without limitation physical rehabilitation or durable medical~~

~~equipment, which generally is not used in the diagnosis or treatment of serious mental illnesses but is used for other injuries, illnesses, and conditions if the other requirements of this subchapter are met.~~

~~(d) A healthcare insurer may utilize common utilization management protocols, including without limitation preadmission screening, prior authorization of service, or other mechanisms designed to limit coverage of service for mental illness to individuals whose diagnosis or treatment coverage is considered medically necessary although the protocols are not used in conjunction with other medical illnesses or conditions covered by the health benefit plan.~~

SECTION 14. Arkansas Code § 23-99-512 is amended to read as follows:

23-99-512. Out-of-network providers.

In the case of a health benefit plan that provides both medical benefits and mental ~~illness~~ health benefits and substance abuse disorder benefits, if the health benefit plan provides coverage for medical benefits provided by out-of-network providers, the health benefit plan shall provide coverage for mental ~~illness~~ health benefits and substance abuse disorder benefits provided by out-of-network providers ~~pursuant to~~ under this subchapter.