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85th General Assembly **A Bill**

Regular Session, 2005 SENATE BILL 233

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By: Representatives Stovall, Thomason, *Bond, Boyd, Bradford, Burris, Chesterfield, Cowling, D. Creekmore, Dangeau, Davenport, Edwards, Elliott, D. Evans, Fite, Goss, R. Green, Hardy, Harrelson, J. Hutchinson, T. Hutchinson, Jackson, D. Johnson, J. Johnson, Lamoureux, Ledbetter, W. Lewellen, Mack, Mahony, Maloch, McDaniel, Pate, Pickett, S. Prater, Pyle, Rainey, Reep, Saunders, L. Smith, Sumpter, Verkamp, Wills, Wood*

For An Act To Be Entitled

AN ACT TO PROVIDE COMPREHENSIVE AND UNIFORM INSURANCE REFORM; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO PROVIDE COMPREHENSIVE AND UNIFORM INSURANCE REFORM.

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

SECTION 1. Purpose.

The General Assembly recognizes that a competitive market for insurance products is vital to Arkansans and that active competition in the insurance marketplace produces the fairest and lowest rates over any given period of time. Furthermore, open and transparent regulation of the insurance industry as well as widespread dissemination of information concerning regulatory actions regarding insurance rates and information helpful to consumers in purchasing and utilizing insurance coverage will assist Arkansans in purchasing, maintaining, and utilizing wisely their insurance coverages. Therefore, the purpose of this act is to assist consumers by providing them

the information and tools necessary to be an informed and educated consumer of insurance coverage.

SECTION 2. Policyholder's Bill of Rights.

(a) The principles expressed in subsection (b) of this section shall serve as standards to be followed by the Insurance Commissioner in exercising the commissioner's powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law, and in adopting rules and regulations:

(b) Policyholders shall have the right to:

(1) Competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies;

(2) Insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy;

(3) An insurer that is financially stable;

(4) Be serviced by a competent, honest insurance producer;

(5) A readable policy;

(6) An insurer that provides an economic delivery of coverage and that tries to prevent losses; and

(7) Balanced and positive regulation by the Insurance Department.

(c) This section shall not be construed as creating, extinguishing, repealing, or limiting any civil cause of action.

SECTION 3. Arkansas Code § 23-61-110 is amended to read as follows:

(a)(1)(A) The Insurance Commissioner may institute such suits or other legal proceedings as may be required for enforcement of any provisions of the Arkansas Insurance Code.

(B) In addition, the commissioner may intervene in any civil suit or administrative hearing initiated by another party against any person or entity regulated by the commissioner under the Arkansas Insurance Code, which suit or proceeding directly relates to the financial condition and solvency of such a person or entity.

(C) Nothing in this subsection shall be construed to limit the commissioner's authority as enumerated in other provisions of the

Arkansas Insurance Code.

(2) If the commissioner has reason to believe that any person has violated any provision of the Arkansas Insurance Code for which criminal prosecution would be in order, he or she shall so inform the prosecuting attorney in whose district any purported violation may have occurred or the Criminal Investigation Division of the State Insurance Department.

(3) If the commissioner finds that any person has violated any provision of the Arkansas Insurance Code, he or she may order restitution of actual losses to affected persons in addition to the denial, suspension, or revocation of any license or certificate or the imposition of any administrative or civil penalty.

(b) The commissioner may proceed in the courts of this state or any reciprocal state to enforce an order or decision in any court proceeding or in any administrative proceeding before the commissioner.

SECTION 4. Arkansas Code § 23-63-110 is amended to read as follows:

§ 23-63-110. ~~Claims which resulted in no loss made under the policy~~ Policy cancellation or premium increase.

(a) No insurance policy or contract, after being issued by an insurer authorized to transact business in this state~~, except the business of life or disability insurance,~~ may be cancelled nor may the premium for such a policy be increased solely as a result of claims made under the policy which resulted in no loss to the insurer.

(b) The following shall not be treated as a claim made under the policy or used to cancel or increase the premium of a policy or contract of insurance:

(1) A request for policy information; or

(2) A discussion between an insured and an insurer or producer as to whether an event is covered under an insurance policy provided that the event does not materially increase the risk insured.

(c) This section shall not apply to annuities or workers' compensation, life, disability, accident and health, or long-term care insurance.

(d) Any insurer that violates the provisions of this section shall be subject to the procedure and penalties provided under the Trade Practices Act, § 23-66-201 et seq.

SECTION 5. Arkansas Code § 23-64-302, concerning exceptions to licensing requirements for insurance producers, is amended to read as follows:

§ 23-64-302. Requirements for licensees -- Exceptions

The provisions of this subchapter shall not apply to:

(1) Those natural persons holding licenses for any kind or kinds of insurance for which an examination is not required by the laws of this state;

(2) Any limited or restricted license the Insurance Commissioner may exempt;

(3) Any natural person who is at least sixty (60) years of age;

(4) Any natural person who has held an active license as an agent, solicitor, consultant, or broker for a period of at least fifteen (15) consecutive years;

(5) The licensee as a firm, limited liability company, or corporation, but this exception does not apply to any individual or natural person unless already exempted;

(6) Nonresident producers;

(7) Licensed insurance consultants for life, accident and health, property, or casualty insurance, or for other lines of insurance; ~~and~~

(8) Nonresident agents and brokers in the first full year of resident licensing following the year after a change in the state of domicile or residency to the State of Arkansas, but thereafter annually or otherwise in accordance with insurance continuing education laws and rules and regulations of the commissioner; and

(9) Any person called to active duty in any branch of the United States military services including, but not limited to, the United States Coast Guard and Reserves, during the entire period of active duty service.

SECTION 6. Arkansas Code § 23-64-506(c), concerning applications for resident insurance producer licenses, is amended to read as follows:

(c) The commissioner may require any documents reasonably necessary to verify the information contained in an application, and shall cause to be conducted an investigation of the applicant's background, trustworthiness, personal and business reputation, and financial responsibility.

SECTION 7. Arkansas Code § 23-64-507(b), concerning the licensing of insurance producers, is amended to read as follows:

(b) An insurance producer license shall remain in effect unless revoked or suspended:

(1) ~~as~~ As long as the fee set forth in § 23-61-401 and any existing or future rule and regulation is paid and education requirements for resident individual producers are met by the due date; or

(2)(A) During any period of active duty in any branch of the United States military services including but not limited to, the United States Coast Guard and Reserves.

(B) The requirements of subdivision (b)(1) of this section are waived during the period of active duty.

SECTION 8. Arkansas Code § 23-64-512(d), concerning available insurance producer sanctions, is amended to read as follows:

(d) In addition to or in lieu of any applicable denial, suspension, or revocation of a license, a person may, after hearing~~,~~:

(1) Be ordered to pay restitution under § 23-61-110; and

(2) Be subject to a civil fine ~~according to~~ under § 23-64-216.

SECTION 9. Arkansas Code Title 23, Chapter 64, subchapter 5 is amended to add a section to read as follows:

§ 23-64-520. Compensation disclosure.

(a) As used in this section:

(1) "Affiliate" means a person that controls, is controlled by, or is under common control with a producer;

(2)(A) "Compensation from an insurer or other third party" means payments, commissions, fees, overrides, bonuses, contingent commissions, loans, stock options, or any other form of valuable consideration, whether or not payable pursuant to a written agreement.

(B) Awards, gifts, and prizes shall be considered "compensation from an insurer or other third party" if the award, gift, or prize is directly tied to the producer's performance; and

(3) "Compensation from the customer" shall not include any fee or similar expense under § 23-66-310 or any fee or amount collected by or

paid to the producer that does not exceed an amount established by the Insurance Commissioner.

(b)(1) Before the placement of insurance business, all insurance producers shall disclose:

(A) Whether the producer or its affiliate represents the customer or the insurer; and

(B) The source or sources of the producer's or affiliate's compensation for the placement.

(2) If the producer represents the insurer, the producer shall disclose to the customer that the producer provides services to the customer on behalf of the insurer.

(3) If the producer receives compensation from the customer for a placement of insurance or acts as a broker as defined by § 23-64-102, the producer shall disclose:

(A) The source or sources of the producer's or affiliate's compensation for the placement; and

(B) Whether the producer or its affiliate will receive compensation for the placement from the insurer or other third party based upon volume, profitability, or other factors, and if the customer requests, the producer shall provide a reasonable estimate of the amount of compensation.

(c) A person shall not be considered a "customer" for purposes of this section if the person is merely:

(1) A participant or beneficiary of an employee benefit plan; or

(2) Covered by a group or blanket insurance policy or group annuity contract sold, solicited or negotiated by the producer or affiliate.

(d) This section shall not apply to:

(1) A person licensed as a producer who acts only as an intermediary between an insurer and the customer's producer, including, but not limited to, a managing general agent, a sales manager, or wholesale broker when acting only as an intermediary;

(2) A reinsurance intermediary;

(3) Any placement involving a residual market mechanism;

(4) Renewals, unless the information previously disclosed under subsection (b) has substantially changed; or

(5) Any placement of credit life or credit disability insurance.

SECTION 10. Arkansas Code § 23-65-101(b), concerning the Insurance Commissioner's cease and desist authority, is amended to read as follows:

(b)(1)(A) The Insurance Commissioner may summarily order a person or entity to cease and desist from an act or practice when the commissioner has reason to believe that the person or entity has not complied with the requirements of this section or any other provision of the Arkansas Insurance Code.

(B) Upon the entry of the cease and desist order, the commissioner shall promptly notify the person or entity named:

(i) That the order has been entered;

(ii) The reasons for the order; and

(iii) Of the person's or entity's right to a hearing on the order.

(2)(A) A hearing shall be held on the written request of the person or entity named in the cease and desist order if the commissioner receives the request within thirty (30) days of the date of the entry of the order or if otherwise ordered by the commissioner.

(B) If no hearing is requested and none is ordered by the commissioner, the order will remain in effect until it is modified or vacated by the commissioner.

(C) If a hearing is requested or ordered and after notice of an opportunity for hearing, the commissioner may affirm, modify, or vacate the cease and desist order.

(D) The person or entity named in the cease and desist order shall have the burden of proving:

(i) That the actions, methods, or practices described in the order are not in violation of the Arkansas Insurance Code; and

(ii) The grounds upon which the commissioner should modify or vacate an order issued under this section.

(3)(A) After issuance of an order under subdivision (b)(1)(B) of this section, the commissioner may apply to Pulaski County Circuit Court to temporarily or permanently enjoin the act or practice and to enforce compliance with the Arkansas Insurance Code or any rule or order under the

Arkansas Insurance Code.

(B) However, the commissioner may apply directly to Pulaski County Circuit Court for a temporary or permanent injunction under subdivision (b)(3)(A) of this section.

(C) Upon a proper showing, the court shall enter a permanent or temporary injunction, restraining order, or writ of mandamus.

(D) The commissioner shall not be required to post a bond.

SECTION 11. Arkansas Code § 23-65-101(h), concerning hearings and orders of the Insurance Commissioner, is amended to read as follows:

(h) The following shall be applicable to hearings held, ~~by and~~ orders issued, and penalties levied by the commissioner under this section:

(1) The provisions of § 23-61-301, as to witnesses and evidence;

(2) The provisions of §§ 23-61-302 and 23-66-214, as to immunity from prosecution;

(3) The provisions of §§ 23-61-303 - 23-61-305, as to hearings;

(4) The provisions of §§ 23-61-306 and 23-61-307, as to orders on hearings and appeals of orders; ~~and~~

(5) The provisions of § 23-66-212, as to judicial review of cease and desist orders; and

(6) The provisions of § 23-66-210(a)(1), as to monetary penalties.

SECTION 12. Arkansas Code § 23-66-204 is amended to read as follows:

The powers vested in the Insurance Commissioner by this subchapter shall be additional to any other powers to order restitution or enforce any penalties, fines, or forfeitures authorized by law with respect to the methods, acts, and practices declared to be unfair or deceptive

SECTION 13. Arkansas Code § 23-66-501(4), concerning the definition of "Fraudulent insurance act", is amended to read as follows:

(4) "Fraudulent insurance act" means an act or omission committed by a person who, knowingly and with intent to defraud, deceive, conceal, or misrepresent ~~commits, or conceals any material information concerning, one or more of the following~~:

(A) ~~Presenting, causing to be presented, or preparing~~

Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, a reinsurer, broker or its agent, or by a broker or agent, false information as part of, in support of, or concerning a fact material to one or more of the following:

(i) An application for the issuance or renewal of an insurance policy or reinsurance contract;

(ii) The rating of an insurance policy or reinsurance contract;

(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract;

(iv) Premiums paid on an insurance policy or reinsurance contract;

(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract;

(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction;

(vii) The financial condition of an insurer or reinsurer;

(viii) The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one or more lines of insurance or reinsurance in all or part of this state by an insurer or reinsurer;

(ix) The issuance of written evidence of insurance; or

(x) The reinstatement of an insurance policy;

(B) ~~Solicitation or acceptance of~~ Solicits or accepts new or renewal insurance risks on behalf of an insurer, reinsurer, or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction;

(C) ~~Removal, concealment, alteration, or destruction of~~ Removes, conceals, alters, or destroys the assets or records of an insurer, reinsurer, or other person engaged in the business of insurance;

(D) ~~Willful embezzlement, abstracting, purloining or conversion of~~ *Embezzles*, abstracts, purloins, or converts moneys, funds, premiums, credits, or other property of an insurer, reinsurer, or person

engaged in the business of insurance;

(E) ~~Transaction of~~ Transacts the business of insurance in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of insurance; or

(F) ~~Attempt to commit, aiding or abetting in~~ Attempts to commit, aids, or abets the commission of, or ~~*conspiracy*~~ *conspires* to commit the acts or omissions specified in this subsection;

(G) Issues false, fake, or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers or insurance binders or other temporary contracts of insurance;

(H) Possesses or possesses in order to distribute, solicit, sell, negotiate or effectuate false, fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance to consumers, leinholders or loss payees, insurance agents or producers, or other persons or entities; or

(I) Possesses any device, software or printing supplies utilized to manufacture false, fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance.

Section 14. Arkansas Code § 23-66-505 is amended to read as follows:

23-66-505. Mandatory reporting of fraudulent insurance acts.

(a) A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed shall provide to the Insurance Commissioner the information required by, and in a manner prescribed by, the commissioner.

(b) Any person engaged in the business of insurance who knowingly fails to report as required by subsection (a) of this section shall be guilty of a misdemeanor and upon conviction shall be punished by a fine not to exceed one thousand dollars ($1,000) or by imprisonment for a period not to exceed one (1) year, or by both fine and imprisonment.

(c) Any other person having knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed may provide

to the commissioner the information required by, and in a manner prescribed by, the commissioner.

(d)(1) Upon the request of the commissioner, a person engaged in the business of insurance shall provide to the commissioner all information the commissioner deems relevant pertaining to any investigation of a fraudulent act or related criminal violation.

(2) The refusal of any person to fully comply with the commissioner's request for information shall be grounds for the suspension, revocation, denial, or nonrenewal of any license or authority held by the person to engage in an insurance or other business subject to the commissioner's jurisdiction.

(3) Any proceeding for the suspension, revocation, denial, or nonrenewal of any license or authority shall be conducted pursuant to § 23-63-213.

SECTION 15. Arkansas Code § 23-66-507(a), concerning the confidentiality of information obtained in the investigation of fraudulent acts, is amended to read as follows:

(a) Notwithstanding any other provision of law, the documents and evidence provided pursuant to §§ 23-66-505 and 23-66-508 or obtained by the Insurance Commissioner in an investigation of suspected or actual fraudulent insurance acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action until the matter under investigation is closed by the ~~Insurance Fraud~~ Criminal Investigation Division of the State Insurance Department with the consent of the commissioner.

SECTION 16. Arkansas Code § 23-66-508(a)(1), concerning the creation of the Insurance Fraud Investigation Division, is amended to read as follows:

(a)(1) The ~~Insurance Fraud~~ Criminal Investigation Division is established within the Arkansas Insurance Department.

SECTION 17. Arkansas Code § 23-67-211 is amended to read as follows:

§ 23-67-211. Filing of rates and other rating information

(a)(1) Filings as to Competitive Markets. In a competitive market, every insurer shall file with the Insurance Commissioner all rates,

supplementary rate information, and supporting information for risks which are to be written in this state. The rates and information shall be filed twenty (20) days prior to the effective date. A filing shall be deemed to meet the requirements of this chapter and to become effective upon the *expiration of the waiting period* *or sooner if approved by the commissioner*.

(2) In a competitive market, if the commissioner determines after a hearing or by agreement that an insurer's rates require closer supervision because of the insurer's financial condition or its rating practices, the insurer shall file with the commissioner at least sixty (60) days prior to the effective date all rates and supplementary rate information and supporting information prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date. A filing shall be deemed to meet the requirements of this chapter and to become effective upon the expiration of the waiting period.

(b) Filings as to Noncompetitive Markets. In a noncompetitive market, every insurer shall file with the commissioner all rates for that market. These rates, supplementary rate information, and supporting information required by the commissioner shall be filed at least sixty (60) days prior to the effective date. Upon application by the filer, the commissioner may authorize an earlier effective date. A filing shall be deemed to meet the requirements of this chapter and to become effective upon the expiration of the waiting period unless disapproved by the commissioner.

(c)(1) If a private passenger *automobile, homeowners multi-peril, or dwelling fire policy*, rate is increased under this section, then the commissioner shall publish notice of the increase and the overall percentage of the rate increase on the State Insurance Department website.

(2) If an automobile, homeowners multi-peril, or dwelling fire policy rate is increased by twenty percent (20%) or more under this section, the commissioner shall publish notice of the increase for three consecutive business days in a newspaper of general circulation in this state in addition to the notice published on the State Insurance Department website.

(d) If an insurer writing private passenger *automobile, homeowners multi-peril, or dwelling fire* insurance revises its rates and the revision results in a premium increase on a renewal policy and the insured will receive a rate increase other than due to a change in the nature of the risk insured, then the insurer shall mail or deliver to the insured and the agent

of record not less than thirty (30) calendar days prior to the effective date of renewal a notice specifically stating the insurer's intention to increase the rate for the renewal.

~~(e)~~ (e) Adherence to Filings. Insurers must adhere to filings made ~~*pursuant to*~~ *under this section until the filings are amended or withdrawn.*

(f) Subsections (c) and (d) of this section take effect on June 30, 2006.

SECTION 18. Title 23, Chapter 67, subchapter 2 is amended to add an additional section to read as follows:

23-67-223. Comparison data for private passenger automobile, homeowners multi-peril, and dwelling fire insurance policies.

(a) The Insurance Commissioner shall compile computerized comparisons *of premiums charged and coverage available for private passenger automobile, homeowners multi-peril, and dwelling fire insurance policies for typical individuals and families broken* down by geographic area and by varying deductible levels.

(b) The commissioner shall make the information compiled under subsection (a) of this section available to consumers upon request.

(c) The commissioner shall engage in a public information campaign to make available to consumers information useful in choosing and maintaining private passenger *automobile, homeowners multi-peril, and dwelling fire* insurance coverage, including, but not limited to, information about certain policy definitions and provisions of which consumers should be particularly aware.

SECTION 19. Arkansas Code Title 23, Chapter 67, is amended to add an additional subchapter to read as follows:

Subchapter 5 — Malpractice Insurance Rates

23-67-501. Applicability.

(a) The provisions of this subchapter shall be applicable to malpractice insurance as defined in 23-62-105(a)(10) except officers and directors *liability and fiduciary insurance.*

(b) Section 23-67-208 shall not apply to malpractice insurance.

23-67-502. Standards for rates.

(a) Rates for malpractice insurance shall not be excessive, inadequate, or unfairly discriminatory.

(b) A rate is excessive if it is likely to produce a profit from Arkansas business that is unreasonably high in relation to past and prospective loss experience or if expenses are unreasonably high in relation to the product or services rendered.

(c) A rate is inadequate if, together with investment income attributable to it, it fails to satisfy projected losses and expenses.

(d)(1) A rate is unfairly discriminatory in relation to another in the same class of business if it does not reflect equitably the differences in expected losses and expenses.

(2) Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors or with like expense factors but different loss exposures if the rates reflect the differences with reasonable accuracy.

23-67-503. Rating criteria.

(a) A malpractice insurer shall consider past and prospective loss experience solely within this state.

(b)(1) If insufficient experience exists within this state upon which a rate can be based, the malpractice insurer may consider experience within any other state or states that have similar claim costs and frequency.

(2) If sufficient experience from any other state is not available, the malpractice insurer may use nationwide experience.

(c) The malpractice insurer, in its rate filing and records, shall provide detailed information on the data supporting the experience it is using.

(d) When experience outside this state is considered, as much weight as possible shall be given to state experience.

23-67-504. Rate administration.

(a)(1) The Insurance Commissioner shall promulgate rules requiring each malpractice insurer to record and report its loss and expense experience and any other data, including reserves, the commissioner considerers necessary to determine whether rates comply with the standards set forth in § 23-67-502.

(2) The information shall be provided in the form prescribed by the commissioner.

(b) The commissioner may require that the malpractice insurer's annual report and any supplemental report that contains information about a malpractice insurer's loss and loss adjustment reserves be accompanied by an opinion signed and sworn to by a qualified and independent actuary verifying that within the nine (9) months prior to the submission of the report:

(1) The actuary has conducted a review and analysis of the malpractice insurer's loss and loss adjustment reserves; and

(2) The reserves are:

(A) Computed in accordance with accepted loss reserving standards; and

(B) Fairly stated in accordance with sound loss reserving principles.

(c) The commissioner shall:

(1) Maintain by malpractice insurer all reports submitted under this section for at least six (6) years; and

(2) Consider the reports in determining the appropriateness of rates for malpractice insurance.

(d) The commissioner may:

(1) Examine and review the assessment of risk for different specialties or practices;

(2) Hold a public hearing on any filing containing a risk assignment for malpractice insurance to determine whether the risk assignment is reasonable; and

(3) Issue orders concerning the risk assignment.

23-67-505. Filing of rating information.

(a) Every malpractice insurer shall file with the Insurance Commissioner every manual of classifications, rules, and rates, every rating plan, and every modification of any manual classification, rule, or rate that it proposes to use in this state.

(b) The expense provisions included in the rates to be used by a malpractice insurer shall reflect its:

(1) Operating methods; and

(2) Actual and anticipated expense experience.

(c)(1) The rates to be used by a malpractice insurer shall contain provisions for contingencies and an allowance permitting a reasonable rate of return.

(2) In determining a reasonable rate of return, consideration shall be given to all investment income reasonably attributable to the insurer's malpractice insurance line of business.

(d) Every filing shall:

(1) State its proposed effective date;

(2) Indicate the character and extent of the coverage contemplated; and

(3) Contain supporting information. The supporting information may include:

(A) The experience or judgment of the malpractice insurer making the filing;

(B) Its interpretation of any statistical data relied upon;

(C) The experience of other malpractice insurers; and

(D) Any other factors that the malpractice insurer deems relevant.

23-67-506. Review of filings.

(a) All malpractice rate filings shall remain on file for public inspection.

(b) Whenever a malpractice insurer files a proposed overall rate increase of *twenty percent (20%)* or greater, it shall:

(1) Publish notice of the filing for three (3) consecutive business days in a newspaper of general circulation in this state; and

(2) Furnish proof of notice to the Insurance Commissioner.

(c) The commissioner may hold a hearing on any malpractice rate increase filing.

(d) The commissioner shall approve or disapprove all malpractice rate *filings subject to the standards for rates under § 23-67-502 within sixty (60) days after the date of the filing.*

(e) Notwithstanding subsection (d) of this section, the commissioner may approve an excessive rate if he or she finds that the failure to approve the rate may tend to substantially lessen competition in the Arkansas

malpractice insurance market.

23-67-507. Disapproval of rates.

The Insurance Commissioner shall follow the procedures set forth in § 23-67-213 when any malpractice rate filing under this subchapter is disapproved.

23-67-508. Administrative procedures.

(a) Administrative procedures exercised by the Insurance Commissioner under this subchapter shall be in accordance with §§ 23-61-303 — 23-61-306.

(b)(1) Appeals from orders of the commissioner under this subchapter shall be made in accordance with § 23-61-307.

(2) Any appeal under this subchapter shall be given precedence over other pending matters so that the court may hold a hearing and reach a decision within thirty (30) days of the filing of the transcript, evidence and files.

23-67-509. Provisions cumulative.

This subchapter supplements existing law. Only those laws and parts of laws in direct conflict with this subchapter are repealed.

23-67-510. EFFECTIVE DATE. This subchapter applies to all malpractice policies issued or renewed on or after January 1, 2006.

SECTION 20. Arkansas Code § 23-76-102(5), concerning the definition of a "health care plan" of a health maintenance organization, is amended to read as follows:

(5) "Health care plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services through an individually underwritten or group master contract, and at least part of the arrangement consists of arranging for, or the provision of, health care services as distinguished from mere indemnification against the cost of the services on a prepaid basis through insurance or otherwise;

SECTION 21. Arkansas Code § 23-89-404 is amended to read as follows:

§ 23-89-404. ~~Property~~ Uninsured motorist property damage coverage.

(a) Every insured purchasing uninsured motorist bodily injury coverage shall be provided an opportunity to include uninsured motorist property damage coverage, subject to provisions filed with and approved by the Insurance Commissioner, applicable to losses in excess of two hundred dollars ($200). However, the deductible of two hundred dollars ($200) shall not apply if:

(1) The vehicle involved in the accident is insured by the same insurer for both collision and uninsured motorist property damage coverage; and

(2) The operator of the other vehicle has been positively identified and is solely at fault.

(b) No insurer shall be required to offer limits of uninsured motorist property damage coverage greater in amount than the property damage liability limits purchased by the insured.

(c)(1) After the uninsured motorist property damage coverage has been made available to an insured one (1) time and has been rejected in writing, it need not again be made available in any continuation, renewal, reinstatement, or replacement of the policy, or the transfer of vehicles insured thereunder, unless the insured makes a written request for the coverage.

(2) However, whenever a new application is submitted in connection with any renewal, reinstatement, or replacement transaction, the provisions of this section shall apply in the same manner as when a new policy is being issued.

(d) As used in this section, "property damage" means damage to the insured vehicle, plus a reasonable allowance for loss of use of the vehicle.

SECTION 22. Arkansas Code § 23-92-101 is amended to read as follows:

§ 23-92-101. Registration or licensure required.

(a) "Multiple employer welfare arrangement" has the same meaning as under 29 U.S.C. § 1002(40), as it existed on January 1, 2003.

(b)(1) Every fully insured multiple employer trust and fully insured multiple employer welfare arrangement that intends to provide ~~accident and health~~ benefits to citizens of this state shall register with the Insurance Commissioner prior to soliciting or enrolling members or prior to conducting

any other business activity in Arkansas.

(2)(A) Each fully insured multiple employer trust and fully insured multiple employer welfare arrangement under this section that is conducting any business activity in Arkansas as of March 18, 2003, shall register with the commissioner no later than July 1, 2003.

(B) After the initial registration, each fully insured multiple employer trust and fully insured multiple employer welfare arrangement under this section that conducts business in Arkansas shall thereafter register with the commissioner no later than January 1 of each year for as long as it continues to do business in Arkansas.

(c)(1) A multiple employer trust or multiple employer welfare arrangement that is not fully insured must obtain a certificate of authority ~~pursuant to § 23-63-201 et seq.~~ under regulations promulgated by the commissioner before doing business in Arkansas.

(2) In order to remain licensed, a multiple employer trust or multiple employer welfare arrangement that is not fully insured must comply with all Arkansas laws that are not inconsistent with the Employee Retirement Income Security Act of 1974, as it existed on January 1, 2003.

(3)(A) The commissioner shall adopt rules regulating multiple employer trusts and multiple employer welfare arrangements that are not fully insured.

(B) The rules shall include information and procedures concerning:

(i) The criteria and application for obtaining a certificate of authority from the State Insurance Department to conduct business in Arkansas;

(ii) The benefits to be offered;

(iii) Financial requirements;

(iv) Fees;

(v) Insolvency procedures;

(vi) Examinations;

(vii) Filing of forms and rates;

(viii) Written disclosures and other consumer protections;

(ix) Reporting requirements;

(x) Excess or stop loss insurance; and

(xi) Other factors the commissioner deems necessary for the effective regulation of multiple employer welfare trusts and multiple employer welfare arrangements that are not fully insured.

SECTION 23. Arkansas Code § 23-92-201 is amended to read as follows:

§ 23-92-201. Definition.

As used in this subchapter, "third party administrator" means any person, firm, or partnership that collects or charges premiums from which or adjusts or settles claims on residents of this state in connection with life or accident and health coverage provided by a self-insured plan or a multiple employer trust or multiple employer welfare arrangement. "Third party administrator" includes administrative-services-only contracts offered by ~~insurance companies~~ insurers and health maintenance organizations but does not include the following persons:

(1) An employer, for its employees or for the employees of a subsidiary or affiliated corporation of the employer;

(2) A union, for its members;

(3) An insurer or health maintenance organization licensed to do business in this state;

(4) A creditor, for its debtors, regarding insurance covering a debt between them;

(5) A credit card-issuing company that advances for or collects premiums or charges from its credit card holders as long as that company does not adjust or settle claims;

(6) An individual who adjusts or settles claims in the normal course of his or her practice or employment and who does not collect charges or premiums in connection with life or accident and health coverage; or

(7) An agency licensed by the insurance commissioner and performing duties pursuant to an agency contract with an insurer authorized to do business in this state.

SECTION 24. Arkansas Code § 23-95-104 is amended to read as follows:

23-95-104. Plan for Coverage -- Requirement.

(a)(1) If the Insurance Commissioner finds, after a hearing, that in all or in any part of this state, any amount or kind of insurance authorized by §§ 23-62-104 and 23-62-105 is not reasonably available in the voluntary

market and that the public interest requires the availability of that insurance, the commissioner shall direct insurers doing business within this state to prepare a voluntary plan which will provide that insurance coverage.

(2) The plan shall be submitted to the commissioner within the time he or she designates and, if approved by him or her, may be put into operation.

(3) If the plan is not approved by the commissioner, or if the plan is not submitted as required, the commissioner may promulgate a plan to provide insurance coverage for any risks in this state which are, based on reasonable underwriting standards, entitled to obtain coverage but are otherwise unable to obtain coverage in the voluntary market.

(b) All orders of the commissioner finding that a line of insurance is not reasonably available in the voluntary market shall consider, to the extent practicable, historical data from the past five years regarding:

(1) Market availability;

(2) Major trends in policy forms, limits, and deductibles offered;

(3) Filed rates for the line if available;

(4) Loss ratios, claims severity, and claims frequency on both the state and national levels;

(5) Availability of surplus lines coverage;

(6) The types of insurers offering the line of insurance in the state;

(7) The existence of any residual market programs, market assistance programs, and captive insurance; and

(8) Whether alternatives to the creation of a risk sharing plan are feasible.

(c) The commissioner may require licensed insurers and surplus lines companies to report historical data to assist the consideration of the factors contained in subsection (b) of this section.

(d) The commissioner shall afford any interested party an opportunity to submit written or oral testimony to assist in the determination required by subsection (a) of this section.

(e) The commissioner shall report to the Legislative Council all lines of insurance he or she determines is not reasonably available in the voluntary market.

SECTION 25. Arkansas Code § 23-100-101 is amended to read as follows:

23-100-101. Title.

This chapter shall be known as the "~~Insurance Fraud~~ "State Insurance Department Criminal Investigation Division Trust Fund Act".

SECTION 26. Arkansas Code § 23-100-102(a)(2), concerning insurer's payment extensions for antifraud assessments, is amended to read as follows:

(2) Absent the commissioner's approval of such an extension for good cause, licensed insurers failing timely to pay the antifraud assessment shall be subject to a penalty of one hundred dollars ($100) per day for each day of delinquency, payable to the ~~Insurance Fraud~~ State Insurance Department Criminal Investigation Division Trust Fund.

SECTION 27. Arkansas Code § 23-100-103(a), concerning the creation of the Insurance Fraud Investigation Division Trust Fund, is amended to read as follows:

(a) There is established on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a fund to be known as the "~~Insurance Fraud~~ State Insurance Department Criminal Investigation Division Trust Fund" to be used to defray the expenses of the ~~Insurance Fraud~~ Criminal Investigation Division of the State Insurance Department in the discharge of its administrative and regulatory powers and duties as prescribed by law.

SECTION 28. Arkansas Code § 23-100-104(a)(1), concerning assessments to fund the Fraud Investigation Division Trust Fund, is amended to read as follows:

(a)(1) Notwithstanding the provisions of § 26-57-601 et seq., the State Insurance Department Trust Fund Act, § 23-61-701 et seq., and other provisions of Arkansas law, all licensed insurers, including, but not limited to, all licensed stock and mutual insurance companies, reinsurers, health maintenance organizations, fraternal benefit societies, hospital and medical service corporations, stipulated premium insurers, farmers' mutual aid associations, and prepaid legal insurers, shall, not later than June 30, 1997, for the 1996-1997 fiscal year, and thereafter annually on or before

June 30 for all subsequent years at the time and in the manner as the Insurance Commissioner shall prescribe, or at times alternate from June 30 annually as the commissioner shall prescribe, pay to the ~~Insurance Fraud~~ State Insurance Department Criminal Investigation Division Trust Fund, in addition to the premium taxes and fees now required under existing law, a nonrefundable antifraud assessment as directed by the commissioner for the reasonable and necessary expenses and operation of the ~~Insurance Fraud~~ Criminal Investigation Division.

SECTION 29. Arkansas Code § 23-100-105 is amended to read as follows:

§ 23-100-105. Insurers' antifraud fees -- Deposit into ~~Insurance Fraud~~ State Insurance Department Criminal Investigation Division Trust Fund.

The Insurance Commissioner shall deposit all antifraud assessments and any penalties assessed under this chapter, as well as any other income received for purposes set out in § 23-100-103(a), into the ~~Insurance Fraud~~ State Insurance Department Criminal Investigation Division Trust Fund as special revenues.

SECTION 30. Arkansas Code § 23-100-107 is amended to read as follows:

§ 23-100-107. ~~Insurance Fraud~~ State Insurance Department Criminal Investigation Division Trust Fund -- Department vouchers and Auditor of State warrants.

All antifraud assessments, penalties, and revenues provided in this chapter received as special revenues for the ~~Insurance Fraud~~ State Insurance Department Criminal Investigation Division Trust Fund and deposited therein shall be deemed for all purposes special revenues of the fund and of the State Insurance Department for the sole support, operation, and maintenance of the ~~Insurance Fraud~~ Criminal Investigation Division of the State Insurance Department, and, when paid into the State Treasury by the Insurance Commissioner, shall be maintained by the State Treasury as the ~~Insurance Fraud~~ State Insurance Department Criminal Investigation Division Trust Fund, separate from all other funds, and available only for the payment of the expenses of the division pursuant to the appropriations therefore. Upon proper voucher from the commissioner, the Auditor of State shall issue his or her warrant on the Treasurer of State in payment of all salaries and other expenses incurred in the administration of this chapter.

SECTION 31. Arkansas Code Title 23, Chapter 97, is amended to add an additional subchapter to read as follows:

23-97-301. Short title.

This subchapter may be known and cited as the "Long-Term Care Insurance Act (2005)".

23-97-302. Purpose.

The purpose of this subchapter is to:

(1) Promote the public interest;

(2) Promote the availability of long-term care insurance policies;

(3) Protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices;

(4) Establish standards for long-term care insurance;

(5) Facilitate public understanding and comparison of long-term care insurance policies; and

(6) Facilitate flexibility and innovation in the development of long-term care insurance coverage.

23-97-303. Scope.

(a) The requirements of this subchapter apply to policies delivered or issued for delivery in this state on or after the effective date of this subchapter.

(b) Except as provided in subsection (c) of this section, this subchapter is not intended to supersede the obligations to comply with other applicable insurance laws that do not conflict with this subchapter.

(c) Laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

23-97-304. Definitions.

As used in this subchapter:

(1) "Applicant" means:

(A) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(B) In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) "Association" means a professional, trade, or occupational association or associations, if the association:

(A) Is composed entirely of individuals that are or were actively engaged in the same profession, trade, or occupation; and

(B) Has been maintained in good faith for purposes other than obtaining insurance.

(3) "Certificate" means any certificate issued under a group long-term care insurance policy delivered or issued for delivery in this state.

(4) "Commissioner" means the Insurance Commissioner of the State of Arkansas.

(5) "Federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the following requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as *it existed on January 1, 2004*:

(A)(i)(a) The only insurance protection provided under the contract is coverage of qualified long-term care services.

(b) A contract satisfies the requirements of this subdivision (4)(A)(i) even though payments are made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(ii)(a) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses:

(1) Are reimbursable under Title XVIII of the Social Security Act, as *it existed on January 1, 2004*; or

(2) Would be reimbursable but for the application of a deductible or coinsurance amount.

(b) The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor.

(c) A contract satisfies the requirements of this subdivision (4)(A)(ii) even though payments are made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(iii) The contract is guaranteed renewable, under section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as *it existed on January 1, 2004*;

(iv) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subdivision (7)(A)(v) of this section;

(v) All refunds of premiums, policyholder dividends, or similar amounts under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund in the event of the death of the insured or a complete surrender or cancellation of the contract can not exceed the aggregate premiums paid under the contract; and

(vi) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as *it existed on January 1, 2004*; or

(B) The portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as *it existed on January 1, 2004*.

(6) "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state and issued for the benefit of its current, former, or retired employees or members to one or more:

(A)(i) Employers;

(ii) Labor organizations;

(iii) Associations; or

(iv) A trust or to the trustees of a fund established by one or more employers, labor organizations; or

(B) Any other group if the commissioner finds that the issuance of the group policy:

(i) Is not contrary to the best interest of the public;

(ii) Results in economies of acquisition or administration; and

(iii) Results in benefits that are reasonable in

relation to the premiums charged.

(6)(A) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services:

(i) For not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; and

(ii) Provided in a setting other than an acute care unit of a hospital.

(B) "Long-term care insurance" includes, but is not limited to:

(i) Group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance;

(ii) A policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity; and

(iii) Qualified long-term care insurance contracts.

(C) Long-term care insurance may be issued by:

(i) Insurers;

(ii) Fraternal benefit societies;

(iii) Nonprofit health, hospital, and medical service corporations;

(iv) Prepaid health plans;

(v) Health maintenance organizations; or

(vi) Any similar organization to the extent they are otherwise authorized to issue life or health insurance.

(D) "Long-term care insurance shall" not include any insurance policy that is offered primarily to provide:

(i) Basic Medicare supplement coverage;

(ii) Basic hospital expense coverage;

(iii) Basic medical-surgical expense coverage;

(iv) Hospital confinement indemnity coverage;

(v) Major medical expense coverage;

(vi) Disability income or related asset-protection

coverage;

(vii) Accident only coverage;

(ix) Specified disease or specified accident coverage; or

(x) Limited benefit health coverage.

(E) "Long-term care insurance" does not include life insurance policies:

(i) That accelerate the death benefit specifically for:

(a) One or more of the qualifying events of terminal illness; or

(b) Medical conditions requiring extraordinary medical intervention or permanent institutional confinement;

(ii) That provide the option of a lump-sum payment for those benefits; and

(iii) Where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(F) Notwithstanding any other provision of this subchapter, any product advertised, marketed, or offered as long-term care insurance is subject to the provisions of this subchapter.

(7) "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by:

(A) An insurer;

(B) A fraternal benefit society;

(C) A nonprofit health, hospital, medical service corporation, or hospital medical service corporation;

(D) A prepaid health plan;

(E) A health maintenance organization; or

(F) Any similar organization.

(8) "Qualified long-term care insurance contract" means the same as "Federally Tax-Qualified long-term care insurance contract".

23-97-305. Requirements for Associations.

(a) Prior to advertising, marketing or offering a policy within this state an association, or the insurer of the association, shall file evidence with the commissioner that the association has:

(1) A minimum of 100 persons;

(2) Been organized and maintained in good faith for purposes other than that of obtaining insurance; and

(3) Have been in active existence for at least one year; and

(4) Have a constitution and bylaws providing that:

(A) The association holds regular meetings not less than annually to further purposes of the members;

(B) Except for credit unions, the association collects dues or solicits contributions from members; and

(C) The members have voting privileges and representation on the governing board and committees.

(b) Thirty (30) days after the filing the association or associations will be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

23-97-306. Extraterritorial jurisdiction -- Group long-term care insurance.

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state determines that the definition of "Group long-term care insurance" under § 23-97-304 has been met.

23-97-307. Disclosure and performance standards for long-term care insurance.

(a) The commissioner may adopt long-term care insurance regulations that include, but are not limited to, standards for full and fair disclosure addressing:

(1) The manner, content, and required disclosures for the sale of long-term care insurance policies;

(2) Terms of renewability;

(3) Initial and subsequent conditions of eligibility;

(4) Non-duplication of coverage provisions;

(5) Coverage of dependents;

(6) Preexisting conditions;

(7) Termination of insurance;

(8) Continuation or conversion of coverage;

(9) Probationary periods;

(10) Limitations, exceptions, reductions and elimination periods;

(11) Requirements for replacement;

(12) Recurrent conditions; and

(13) Definitions of terms.

(b) No long-term care insurance policy shall:

(1) Be cancelled, not renewed, or otherwise terminated because of age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form of coverage within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3)(A) Provide coverage for skilled nursing care only; or

(B) Provide significantly more coverage for skilled care within a facility than coverage for lower levels of care.

23-97-308. Preexisting condition.

(a) No long-term care insurance policy or certificate other than a policy or certificate issued to a group approved by the Insurance Commissioner under § 23-97-304(6)(B) shall:

(1) Use a definition of “preexisting condition” that is more restrictive than the following: "Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person"; or

(2) Exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(b) The insurance commissioner may extend the limitation periods set forth in subsection (a) of this section for specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

(c)(1) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant when underwriting in accordance with the insurer's established underwriting standards.

(2) Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (a)(2) of this section expires.

(3) No long-term care insurance policy or certificate may exclude, or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (a)(2) of this section.

23-97-309. Prior hospitalization or institutionalization.

(a) No long-term care insurance policy shall be delivered or issued for delivery in this state if the policy conditions eligibility for any benefits:

(1) On a prior hospitalization requirement;

(2) Provided in an institutional care setting on the receipt of a higher level of institutional care; or

(3) Other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(b)(1) A long-term care insurance policy containing post-confinement, post-acute care, or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" the limitations or conditions, including any required number of days of confinement.

(2) A long-term care insurance policy or rider that conditions eligibility for non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

(c) No long-term care insurance policy or rider that provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

23-97-310. Loss ratio standards.

(a)(1) The commissioner may adopt rules establishing loss ratio standards for long-term care insurance policies.

(2) A specific reference to long-term care insurance policies shall be contained in the rules.

23-97-311. Right to return -- Free look.

(a) Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(b) Long-term care insurance policies and certificates shall contain a notice prominently printed on or attached to the first page stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(c) If an application is denied, the issuer shall refund to the applicant any premium and any other fee paid by the applicant to apply within thirty (30) days of the denial.

23-97-312. Outline of coverage.

(a)(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the outline of coverage and its purpose.

(2) The Insurance Commissioner shall prescribe a standard format for the outline, including style, arrangement, overall appearance, and content.

(3) In the case of agent solicitations an agent shall deliver the outline of coverage prior to the presentation of an application or

enrollment form.

(4) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(5)(A) In the case of a policy issued to a group approved by the Commissioner under § 23-97-304(6)(B), an outline of coverage shall not be required to be delivered if the information described in subsection (b) of this section is provided to applicants in other materials relating to enrollment.

(B) Materials relating to enrollment shall be made available to the commissioner upon request.

(b) The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(3)(A) A statement of the terms under which the policy or certificate or both may be continued in force or discontinued, including any reservation in the policy of a right to change premium.

(B) Continuation or conversion provisions of group coverage shall be specifically described;

(4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(5) A description of the terms under which the policy or certificate may be returned and premium refunded;

(6) A brief description of the relationship between cost of care and benefits; and

(7) A statement that discloses to the policyholder or certificateholder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as *it existed on January 1, 2004*.

23-97-313. Certificates.

A certificate issued for delivery in this state under a group long-term care insurance policy shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions.

23-97-314. Delivery of policy and summary -- Disclosures.

(a) If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.

(b)(1) At the time of the delivery of the policy, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider.

(2) In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request or at the time of policy delivery, whichever first occurs.

(3) The summary shall comply with all applicable requirements and include:

(A) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(B) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(C) Any exclusions, reductions, and limitations on long-term care benefits;

(D) A statement that any long-term care inflation protection option, if required by rules and regulations of the Insurance Commissioner, is not available under the policy;

(4) If applicable to the policy type, the summary shall also include:

(A) A disclosure of the effects of exercising other rights under the policy;

(B) A disclosure of guarantees related to long-term care

costs of insurance charges; and

(C) Current and projected maximum lifetime benefits.

23-97-315. Acceleration of death benefit.

(a) Any time a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder.

(b) The report shall include:

(1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy, including but not limited to, death benefits or cash values, due to the payment of long-term care benefits; and

(3) The remaining amount of long-term care benefits.

23-97-316. Denial of claims.

If a claim under a long-term care insurance contract is denied the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificateholder or a representative of the policyholder or certificateholder:

(1) Provide a written explanation of the reasons for the denial; and

(2) Make available all information directly related to the denial.

23-97-317. Offer of long-term care or nursing home insurance.

Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance shall comply with the provisions of this subchapter.

23-97-318. Incontestability Period.

(a) If a long-term care insurance policy or certificate has been in force for less than six (6) months and the insurer relied upon a material misrepresentation in providing coverage, then the insurer may:

(1) Rescind the policy or certificate; or

(2) Deny an otherwise valid long-term care insurance claim.

(b) If a long-term care insurance policy or certificate has been in

force for at least six (6) months but less than two (2) years and the insurer relied upon a material misrepresentation in providing coverage that pertains to the condition for which benefits are sought, then the insurer may:

(1) Rescind the policy or certificate; or

(2) Deny an otherwise valid long-term care insurance claim.

(c) A policy or certificate that has been in force for two (2) years or more may be contested only by showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(d)(1) No long-term care insurance policy or certificate may be field issued based on medical or health status.

(2) For purposes of this section, "field issued" means a policy or certificate issued by an agent or a third-party administrator under the underwriting authority granted to the agent or third party administrator by an insurer.

(e) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

(f)(1) Except as provided in subdivision (f)(2) of this section, this section shall apply to all life insurance policies that accelerate benefits for long-term care.

(2)(A) In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care.

(B) The remaining death benefit shall be governed by § 23-81-105.

23-97-319. Nonforfeiture Benefits.

(a)(1) Except as provided in subsection (b) of this section, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate containing a nonforfeiture benefit.

(2) The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy.

(3) If the policyholder or certificateholder declines the nonforfeiture benefit, then the insurer shall provide a contingent benefit

upon lapse that shall be available for the period of time specified by the Insurance Commissioner following a substantial increase in premium rates.

(b)(1) When a group long-term care insurance policy is issued, the offer required in subsection (a) of this section shall be made to the group policyholder.

(2) However, if the policy is issued as group long-term care insurance as defined under 23-97-304(6)(B), other than to a continuing care retirement community or similar entity, then the offering shall be made to each proposed certificateholder.

(c) The commissioner shall promulgate rules specifying:

(1) The type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates;

(2) The standards for nonforfeiture benefits; and

(3) The rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse under subsection (a) of this section.

23-97-320. Authority to Promulgate Regulations.

The Insurance Commissioner shall issue rules for long-term care insurance to:

(1) Promote premium adequacy;

(2) Protect the policyholder in the event of substantial rate increases; and

(3) Establish minimum standards for:

(A) Marketing practices;

(B) Agent compensation;

(C) Agent testing;

(D) Penalties; and

(E) Reporting practices.

23-97-321. Penalties.

In addition to any other penalties provided by the laws of this state, any insurer or agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of

long-term care insurance is subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars ($10,000), whichever is greater.

SECTION 32. On the effective date of this Act, Arkansas Code Title 23, Chapter 97, Subchapter 2 is repealed.

~~23-97-201. Short title.~~

~~This subchapter may be known and cited as the "Long-Term Care Insurance Act".~~

~~23-97-202. Purpose.~~

~~The purpose of this subchapter is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.~~

~~23-97-203. Definitions.~~

~~As used in this subchapter:~~

~~(1) "Applicant" means:~~

~~(A) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and~~

~~(B) In the case of a group long-term care insurance policy, the proposed certificate holder;~~

~~(2) "Certificate" means any certificate of insurance or evidence of coverage issued to a resident of this state regardless of the state in which the policy was issued;~~

~~(3) "Commissioner" means the Insurance Commissioner;~~

~~(4) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:~~

~~(A) One (1) or more employers or labor organizations, or to a trust or to the trustees of a fund established by one (1) or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a~~

~~combination thereof, of the labor organization; or~~

~~(B) Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such an association:~~

~~(i) Is composed of individuals, all of whom are or were actively engaged in the same profession, trade, or occupation; and~~

~~(ii) Has been maintained in good faith for purposes other than obtaining insurance; or~~

~~(C)(i) An association or a trust or the trustee or trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations.~~

~~(ii) Prior to advertising, marketing, or offering such a policy or contract within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations:~~

~~(a) Have at the outset a minimum of one hundred (100) persons;~~

~~(b) Have been organized and maintained in good faith for purposes other than that of obtaining insurance;~~

~~(c) Have been in active existence for at least one (1) year; and~~

~~(d) Have a constitution and bylaws which provide that:~~

~~(1) The association or associations hold regular meetings not less than annually to further purposes of the members;~~

~~(2) Except for credit unions, the association or associations collect dues or solicit contributions from members; and~~

~~(3) The members have voting privileges and representation on the governing board and committees.~~

~~(iii) Thirty (30) days after such a filing, the association or associations will be deemed to satisfy such organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements; or~~

~~(D) A group other than as described in subdivisions (4)(A)-(C) of this section, subject to a finding by the commissioner that:~~

~~(i) The issuance of the group policy is not contrary to~~

~~the best interest of the public;~~

~~(ii) The issuance of the group policy would result in economies of acquisition or administration; and~~

~~(iii) The benefits are reasonable in relation to the premiums charged;~~

~~(5)(A)(i) "Long-term care insurance" means any insurance policy, contract certificate, rider, or other evidence of coverage issued, issued for delivery, advertised, marketed, or offered in this state to provide coverage for not less than twelve (12) consecutive months for each covered person, on an expense-incurred, indemnity, prepaid, or other basis, for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital.~~

~~(ii) "Long-term care insurance" includes:~~

~~(a) Group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance;~~

~~(b) A policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity; and~~

~~(c) Qualified long-term care insurance contracts.~~

~~(iii) Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit hospital and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization to the extent they are otherwise authorized to issue life or accident and health insurance.~~

~~(B)(i) Long-term care insurance shall not include any insurance policy which is offered primarily to provide:~~

~~(a) Basic medicare supplement coverage;~~

~~(b) Basic hospital expense coverage;~~

~~(c) Basic medical-surgical expense coverage;~~

~~(d) Hospital confinement indemnity coverage;~~

~~(e) Major medical expense coverage;~~

~~(f) Disability income or related asset-protection coverage;~~

~~(g) Accident-only coverage;~~

~~(h) Specified disease or specified accident coverage; or~~

~~(i) Limited benefit health coverage.~~

~~(ii) With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one (1) or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.~~

~~(iii) Notwithstanding any other provision contained in this section, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of this subchapter;~~

~~(6) "Policy" means any policy, contract, subscriber agreement, certificate, rider, or endorsement or other evidence of coverage delivered or issued for delivery in this state by an issuer, fraternal benefit society, nonprofit hospital or medical service corporation, prepaid health plan, health maintenance organization, or similar organization;~~

~~(7) "Qualified long-term care insurance contract" means any individual or group insurance contract if it meets the requirements of section 7702B of the Internal Revenue Code, as amended, and if:~~

~~(A) The only insurance protection provided under the contract is coverage of qualified long-term care services;~~

~~(B) The contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. This subdivision (7)(B) does not apply to a contract that makes per diem or other periodic payment without regard to expenses;~~

~~(C) The contract is guaranteed renewable;~~

~~(D) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. All refunds of premiums, and all policyholder dividends or similar amounts, under such a contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund of the~~

~~aggregate premium paid under the contract may be allowed in the event of the death of the insured or a complete surrender or cancellation of the contract; and~~

~~(E) The contract contains the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code;~~

~~(8) "Qualified long-term care insurance contract" also means any life insurance contract which provides long-term care coverage by rider or as part of the contract as long as the contract complies with the applicable provisions of section 7702B of the Internal Revenue Code, as amended; and~~

~~(9) "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance for personal care services for which an insured is eligible under a qualified long-term care insurance contract, and which are provided pursuant to a plan of care prescribed by a licensed health care practitioner.~~

~~23-97-204. Scope.~~

~~The requirements of this subchapter shall apply to policies delivered or issued for delivery in this state on July 1, 1997. This subchapter is not intended to supersede the obligations of entities subject to this subchapter to comply with the substance of other applicable insurance laws insofar as they do not conflict with this subchapter, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance.~~

~~23-97-205. Required compliance.~~

~~No policy or contract may be advertised, marketed, or offered as long-term care or nursing home insurance in this state unless it complies with the provisions of this subchapter.~~

~~23-97-206. Administrative procedures.~~

~~Regulations adopted pursuant to this subchapter shall be in accordance with the provisions of § 23-61-108 and the Arkansas Administrative Procedure Act, § 25-15-201 et seq.~~

~~23-97-207. Group long-term care insurance.~~

~~No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in § 23-97-203(4)(D), unless the Insurance Commissioner has determined that the group policy meets the requirements of § 23-97-203(4)(D).~~

~~23-97-208. Disclosure and performance standards for long-term care insurance.~~

~~(a) The Insurance Commissioner may adopt regulations that include standards for full and fair disclosure, setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.~~

~~(b) No long-term care insurance policy may:~~

~~(1) Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or~~

~~(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or~~

~~(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.~~

~~(c) The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.~~

~~(d) MONTHLY REPORTS. Any time a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:~~

~~(1) Any long-term care benefits paid out during the month;~~

~~(2) An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and~~

~~(3) The amount of long-term care benefits existing or remaining.~~

~~(e) CLAIM DENIALS. If a claim under a qualified long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificate holder, or a representative thereof:~~

~~(1) Provide a written explanation of the reasons for the denial; and~~

~~(2) Make available all information directly related to the denial.~~

~~(f) INCONTESTABILITY PERIODS.~~

~~(1) For a policy or certificate that has been in force for less than six (6) months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance of the coverage.~~

~~(2) For a policy or certificate that has been in force for at least six (6) months but less than two (2) years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.~~

~~(3) After a policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone. Such a policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.~~

~~(g) FIELD ISSUED POLICIES.~~

~~(1) No long-term care insurance policy or certificate may be field issued based upon medical or health status.~~

~~(2) For purposes of this section, "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.~~

~~(h) POLICY RESCISSIONS. If an insurer has paid benefits under the~~

~~long-term care insurance policy or certificate, the benefit payments may not be recovered in the event that the policy or certificate is rescinded.~~

~~(i) NONFORFEITURE BENEFITS.~~

~~(1) No long-term care insurance policy or certificate may be delivered or issued for delivery in this state unless the policyholder at the time of the application is offered the option of purchasing a policy or certificate that provides for nonforfeiture benefits to the defaulting or surrendering policyholder or certificate holder. The commissioner shall promulgate a regulation specifying the type or types of nonforfeiture benefits to be included in such policies and certificates and the standards for the benefits.~~

~~(2) Nonforfeiture benefits for qualified long-term care insurance contracts shall offer at least a reduced paid-up insurance benefit, an extended term insurance benefit, the offer of a short-ended benefit period, or other similar offerings approved by the United States Secretary of the Treasury, and shall be provided as specified in regulations. The issuer of the contract may refund premiums upon death of the insured or upon complete surrender or cancellation of the contract or policy, as long as the refund does not exceed the aggregate premiums paid for the contract or policy.~~

~~23-97-209. Preexisting condition.~~

~~(a)(1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in § 23-97-203(4)(A) shall use a definition of "preexisting condition" which is more restrictive than the following:~~

~~"Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within six (6) months preceding the effective date of coverage of an insured person.~~

~~(2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in § 23-97-203(4)(A) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such a loss or confinement begins within six (6) months following the effective date of coverage of an insured person.~~

~~(3) The Insurance Commissioner may extend the limitation periods~~

~~set forth in this section as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.~~

~~(4) The definition of "preexisting condition" in subdivision (a)(1) of this section does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the applicant's answers on that application, conduct underwriting in accordance with that insurer's established underwriting standards.~~

~~(b)(1) Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subdivision (a)(2) of this section expires.~~

~~(2) No long-term insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subdivision (a)(2) of this section.~~

~~23-97-210. Prior hospitalization or institutionalization.~~

~~(a) Effective April 6, 1994, no long-term care insurance policy or certificate may be delivered or issued for delivery in this state if the policy or certificate:~~

~~(1) Conditions eligibility for any benefits on a prior hospitalization requirement;~~

~~(2) Conditions eligibility for benefits to be provided in an institutional care setting on the receipt of a higher level of institutional care; or~~

~~(3) Conditions eligibility for any benefits other than waiver of premium, postconfinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.~~

~~(b) Effective April 6, 1994, a long-term care insurance policy or certificate containing any limitations or conditions for eligibility specified in subdivision (a)(3) of this section shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions,~~

~~including any required number of days of confinement.~~

~~(c) A long-term care insurance policy or certificate:~~

~~(1) Containing a benefit advertised, marketed, or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement;~~

~~(2) Which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days for which benefits are paid; and~~

~~(3) Which provides for waiver of premium, postconfinement, post-acute care, or recuperative benefits only following institutionalization shall not condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.~~

~~23-97-211. Outline of coverage.~~

~~(a)(1) A written outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation with a notice which prominently directs the attention of the recipient to the document and its purpose.~~

~~(2) The Insurance Commissioner shall prescribe a standard format for such an outline, including style, arrangement, overall appearance, and content.~~

~~(3) In the case of agent solicitations, an agent must deliver the outline of coverage to the applicant prior to the presentation of an application or enrollment form.~~

~~(4) In the case of direct response solicitations, the outline of coverage must be presented to the applicant in conjunction with any application or enrollment form.~~

~~(b) The outline of coverage shall include:~~

~~(1) A description of the principal benefits and coverage provided in the policy or certificate;~~

~~(2) A statement of the principal exclusions, reductions, and limitations contained in the policy or certificate;~~

~~(3) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including~~

~~any reservation in the policy of the issuer's right to change the premium. Continuation or conversion provisions of group coverage shall be specifically described;~~

~~(4) A statement in bold type that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;~~

~~(5) A description of the terms under which the policy or certificate may be returned and premium refunded; and~~

~~(6) A brief description of the relationship of cost of care to benefits.~~

~~(c) If the policy or certificate is intended to be a qualified long-term care insurance contract, the outline of coverage shall also include a statement that discloses to the policyholder or certificate holder that the policy is intended to be a qualified long-term care insurance contract.~~

~~23-97-212. Certificates.~~

~~(a) A certificate issued pursuant to a group long-term care insurance policy shall include:~~

~~(1) A description of the principal benefits and coverage provided in the policy;~~

~~(2) A statement of the principal exclusions, reductions, and limitations contained in the policy; and~~

~~(3) A statement that the group master policy determines governing contractual provisions.~~

~~(b) The issuer of a qualified long-term care insurance contract shall deliver to the applicant, policyholder, or certificate holder the contract or certificate no later than thirty (30) days after the date of approval.~~

~~23-97-213. Right to return - Free look.~~

~~(a)(1) A long-term care insurance applicant, policyholder, or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the entire premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.~~

~~(2)(A) Long-term care insurance policies and certificates shall be accompanied by a notice prominently printed on the first page or attached~~

~~thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the entire premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in § 23-97-203(4)(A), the applicant or the policyholder is not satisfied for any reason.~~

~~(B) If an application for a qualified long-term care contract is denied, the issuer shall refund to the applicant any premium and any other fee submitted by the applicant within thirty (30) days of the denial.~~

~~(b)(1) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within thirty (30) days of its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason.~~

~~(2) Long-term care insurance policies issued pursuant to a direct response solicitation shall be accompanied by a notice prominently printed stating in substance that the insured person shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason.~~

SECTION 33. Arkansas Code Title 23, Chapter 63, Subchapter 1 is amended to add an additional section to read as follows:

23-63-111. Policyholder's right to loss information.

(a)(1) Upon written request, each licensed property and casualty insurer shall mail or deliver the policyholder's claim loss information to the policyholder or his or her authorized producer within thirty (30) days of the request by the policyholder.

(2)(A) "Claim loss information" as used in this section means the date of loss, property insured, and amount paid.

(B) "Claim loss information" does not include supporting claim file documentation, including, but not limited to, copies of claim files, investigation reports, evaluation statements, insured's statements, and documents protected by a common law or statutory privilege.

(b) The insurer may charge a reasonable fee for providing the

information.

(c) The insurer shall not be required to maintain claim loss information for more than five (5) years following the termination of coverage.

SECTION 34. Arkansas Code §23-65-311 is amended by adding an additional subsection to read as follows:

"(e)(1) Upon written request, each approved but non-admitted surplus line insurer shall mail or deliver the policyholder's claim loss information to the policyholder or his or her surplus line broker within thirty (30) days of the request by the policyholder.

(2)(A) "Claim loss information" as used in this subsection (e) means the date of loss, property insured, and amount paid.

(B) "Claim loss information" does not include supporting claim file documentation, including, but not limited to, copies of claim files, investigation reports, evaluation statements, insured's statements, and documents protected by a common law or statutory privilege.

(3) The surplus line insurer may charge a reasonable fee for providing the information as part of the expense of underwriting the policy.

(4) The surplus line insurer shall not be required to maintain claim loss information for more than five (5) years following the termination of coverage.

/s/ B. Johnson

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1