As Engrossed: 3/3/95 3/15/95 3/16/95

State of Arkansas
80th General Assembly
Regular Session, 1995
By: Representative Thomas

A Bill

HOUSE BILL 1730

For An Act To Be Entitled

"AN ACT TO PROVIDE FOR THE PROTECTION AGAINST INSOLVENCY OF PREPAID LIMITED HEALTH SERVICE ORGANIZATIONS; AND FOR OTHER PURPOSES."

Subtitle

"TO PROVIDE FOR THE PROTECTION AGAINST INSOLVENCY OF PREPAID LIMITED HEALTH SERVICE ORGANIZATIONS."

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

SECTION 1. For the purposes of this act:

(a) "Commissioner" means the State Insurance Commissioner;

(b) "Enrollee" means an individual, including dependents, who is entitled to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this act;

(c) "Evidence of Coverage" means the certificate, agreement or contract issued pursuant to this act setting forth the coverage to which an enrollee is entitled.

(d) "Limited health service" shall mean dental care services, those services that are provided by only one group of similar health services providers, and such other services as determined by commissioner to be limited health services. The term "limited health service" shall not include any vision care services or any mental health services.

(e) "Prepaid limited health service organization" means any corporation, partnership or other entity which, in return for a prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Prepaid limited health service organization

does not include (1) an entity otherwise authorized pursuant to the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnity for any limited health service; or (2) an entity that meets the requirements of Section 6 of this act; or (3) a provider or entity when providing or arranging for the provision of limited health services pursuant to a contract with a prepaid limited health service organization or with an entity described in (1) or (2) of this definition or (4) any entity that guarantees any level of provider income such as, but not limited to, guaranteeing a percentage of a provider's normal fees.

(f) "Provider" means any physician, dentist, health facility, or other person or institution which is licensed or otherwise authorized to deliver or furnish limited health service(s).

(g) "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this act.

SECTION 2. Certificate of Authority Required.

A. No person, corporation, partnership, firm or other entity may operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner pursuant to this act. Any firm, company or association lawfully organized and existing and lawfully doing business pursuant to other chapters of the Insurance Code as of the effective date of this act, is not required to reorganize or comply with the provisions of this act.

B. The certificate of authority shall grant the prepaid limited health service organization the ability to operate in only those counties initially approved by the commissioner. Before the prepaid limited health service organization can operate in other counties in Arkansas that it was not initially approved for, the commissioner must approve such. The commissioner will review such application for extension into other counties by utilizing the standards in Section 3.

C. Any entity authorized pursuant to the laws of this state to operate a health maintenance organization and has been operating as a prepaid limited health service organization as described in Section 1 may modify their

certificate of authority to comply with Section 3 of this act and will be exempt from the original filing fee in Section 23. This exemption is contingent on the entity totally converting the entire company to a "prepaid limited health service organization".

SECTION 3. Application for Certificate of Authority.

An application for a certificate of authority to operate a prepaid limited health service organization shall be filed with the Commissioner on a form prescribed by the Commissioner. Such application shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by the following:

(1) A copy of the applicant_s basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments to such documents;

(2) A copy of all bylaws, rules, regulations, or similar documents, if any, regulating the conduct of the applicant_s internal affairs;

(3) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant_s affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent (10%) or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association;

(4) A statement generally describing the applicant, its facilities, personnel and the limited health service or services to be offered;

(5) A copy of the form of any contract made, or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

(6) A copy of the form of any contract made, or to be made between the applicant and any person listed in subsection (3) of this section;

(7) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership or other entity for the performance on the applicant_s behalf of any functions including, but not

limited to, marketing, administration, enrollment, investment management and subcontracting for the provision of limited health services to enrollees;

(8) A copy of the form of any group contract which is to be issued to employers, unions, trustees, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

(9) A copy of the applicant_s most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant_s parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant_s parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, shall satisfy this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this act;

(10) A copy of the applicant_s financial plan, including a three (3) year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

(11) A schedule of rates and charges;

(12) A description of the proposed method of marketing;

(13) A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with §§ 23-63-301, et seq.;

(14) A description of the complaint procedures to be established and maintained as required under Section 12 of this act;

(15) A description of the quality assessment and utilization review procedures to be utilized by the applicant as approved by the Arkansas Department of Health;

(16) A description of how the applicant will comply with Section 17 of this act;

(17) The fee for issuance of a certificate of authority provided in Section 23 of this act; and

(18) Such other information as the commissioner may reasonably require to make the determinations required by this act.

SECTION 4. Issuance of Certificate of Authority; Denial.

(a) Following receipt of an application filed pursuant to Section 3 of this act, the commissioner shall review such application and notify the applicant of any deficiencies contained therein. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

(1) The requirements of Section 3 of this act have been fulfilled;

(2) The individuals responsible for conducting the applicant_s affairs are competent, trustworthy and possess good reputations, and have had appropriate experience, training or education;

(3) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(A) The financial soundness of the applicant_s arrangements for limited health services and the minimum standard rates, deductibles, copayments and other patient charges used in connection therewith;

(B) The adequacy of working capital, other sources of funding, and provisions for contingencies;

(C) Any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization; and

(D) The manner in which the requirements of Section 17 of this act have been fulfilled;

(4) The agreements with providers for the provision of limited health services contain the provisions required by Section 16 of this act; and

(5) Any deficiencies identified by the commissioner have been corrected.

(b) If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The prepaid limited health service organization shall have thirty (30) days from the date of receipt of the notice to request a hearing before the

commissioner pursuant to §§ 23-61-301, et seq.

SECTION 5. Effect on organizations operating on effective date of this act.

Within one hundred twenty (120) days after the effective date of this act, every prepaid limited health service organization operating in this state without a certificate of authority shall submit an application for a certificate of authority to the commissioner. Each such organization may continue to operate during the pendency of its application. In the event an application is denied under this section, the applicant will then be treated as a prepaid limited health service organization whose certificate of authority has been revoked.

SECTION 6. Filing requirements for authorized entities.

(a) Any entity authorized pursuant to the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health, hospital or medical service corporation or a fraternal benefit society and which is not otherwise authorized pursuant to the laws of this state to offer limited health services on a per capita or fixed prepayment basis may do so by filing for approval with the commissioner the information requested by Section 3(4), (5), (7), (8), (10), (11), (12) and (15) of this act and any subsequent material modification or addition thereto.

(b) If the commissioner disapproves the filing, the procedures set forth in Section 4(b) of this act shall be followed.

SECTION 7. Changes in rates and benefits, material modifications; addition of limited health services.

(a) A prepaid limited health service organization shall file with the commissioner prior to use, a notice of any change in rates, charges or benefits and of any material modification of any matter or document furnished pursuant to Section 3 of this act, together with such supporting documents as are necessary to fully explain the change or modification. If the commissioner does not disapprove such filing within sixty (60) days of its filing, such filing shall be deemed approved.

(b) If a prepaid limited health service organization desires to add one (1) or more limited health services, it shall file a notice with the commissioner and, at the same time, shall submit the information required by Section 3 of this act if different from that filed with the prepaid limited health service organization_s application, and shall demonstrate compliance with Sections 16, 17 and 23 of this act. If the commissioner does not disapprove such filing within thirty (30) days of its filing, such filing shall be deemed approved.

(c) If such filings are disapproved, the commissioner shall notify the prepaid limited health services organization and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization shall have thirty (30) days from the date of receipt of notice to request a hearing before the commissioner pursuant to §§ 23-61-301, et seq.

SECTION 8. Evidence of coverage.

(a) Every subscriber shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

(1) The limited health services to which each enrollee is entitled;

(2) Any limitation of the services, kinds of services or benefits to be provided, and exclusions, including any deductible, copayment or other charges;

(3) Where and in what manner information is available as to where and how services may be obtained; and

(4) The method for resolving complaints.

(b) Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

SECTION 9. Rates and charges.

The rates and charges shall be reasonable in relation to the services provided. The commissioner may request information from the prepaid limited health service organization supporting the appropriateness of the rates and charges.

SECTION 10. Construction with other laws.

(a)(1) A prepaid limited health service organization organized under the laws of this state shall be deemed to be a domestic insurer for purposes of §§ 23-63-501, et seq. or §§ 23-69-101, et seq. unless specifically exempted in writing from one (1) or more of the provisions of such act by the commissioner.

(2) A prepaid limited health service organization shall be subject to §§ 23-61-301, et seq., §§ 23-63-501, et seq., §§ 23-66-201, et seq., and §§ 23-69-101, et seq., and the Patient Protection Act of 1995 being Act 505 of 1995.

(3) No other provision of the insurance code shall apply to a prepaid limited health service organization unless such an organization is specifically mentioned therein.

(b) The provision of limited health services by a prepaid limited health service organization or other entity pursuant to this act shall not be deemed to be the practice of medicine or other healing arts.

(c) Solicitation to arrange for or provide limited health services in accordance with this act shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

SECTION 11. Nonduplication of coverage.

Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health or hospital or medical service corporation or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services, whether in the form of services, supplies or reimbursement, insofar as the coverage or service is provided in accordance with this act under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health or hospital or medical service corporation or a fraternal benefit society.

SECTION 12. Complaint system.

Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. Nothing herein shall be construed to preclude an enrollee or a provider from filing a complaint with the commissioner or as limiting the commissioner_s ability to investigate such complaints.

SECTION 13. Examination of organization.

(a) The commissioner may examine the affairs of any prepaid limited health service organization as often as is reasonably necessary to protect the interests of the people of this state, but not less frequently than once every three (3) years.

(b) Every prepaid limited health service organization shall make its relevant books and records available for such examinations and in every way cooperate with the commissioner to facilitate such examinations.

(c) The reasonable expenses of an examination under this section shall be charged to the organization being examined and remitted to the commissioner.

(d) In lieu of such examination, the commissioner may accept the report of an examination made by the commissioner of another state.

SECTION 14. Investments.

The funds of a prepaid limited health service organization shall be invested only in accordance with the guidelines established by the National Association of Insurance Commissioners for investments by health maintenance organizations.

SECTION 15. Agents.

No individual may apply, procure, negotiate, or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise authorized to sell accident and health insurance policies, health, hospital or medical service contracts, or health maintenance organization contracts.

SECTION 16. Contracts with providers.

All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment or other basis shall contain or shall be construed to contain the following terms and conditions:

(1) In the event the prepaid limited health service organization fails to pay for limited health services for any reason whatsoever, including but not limited to, insolvency or breach of this contract, enrollees shall not be liable to the provider for any sums owed to the provider under this contract.

(2) No provider, agent, trustee or assignee thereof may maintain an action at law or attempt to collect from the enrollee sums owed to the provider by the prepaid limited health service organization.

(3) These provisions do not prohibit collection of uncovered charges consented to by enrollees or collection of copayments from enrollees.

(4) These provisions shall survive the termination of this contract, regardless of the reason giving rise to termination.

(5) Termination of this contract shall not release the provider from completing procedures in progress on enrollees then receiving treatment for a specific condition for a period not to exceed one hundred twenty (120) days, at the same schedule of copayment or other applicable charge in effect upon the effective date of termination of this contract.

(6) Any amendment to these foregoing provisions of this contract must be submitted to and be approved by the commissioner prior to becoming effective.

SECTION 17. Protection against insolvency; deposit.

(a)(1) Except as approved in accordance with Subsection (d) of this section, each prepaid limited health service organization shall, at all times, have and maintain tangible net equity equal to the greater of:

(A) Fifty thousand dollars ($50,000); or

(B) Two percent (2%) of the organization_s annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

(2) A prepaid limited health service organization that has uncovered expenses in excess of fifty thousand dollars ($50,000), as reported on the most recent annual financial statement filed with the commissioner,

shall maintain tangible net equity equal to twenty-five percent (25%) of the uncovered expense in excess of fifty thousand dollars ($50,000) in addition to the tangible net equity required by Subsection (a)(1) of this section .

(b) For the purpose of this section, "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due.

(c)(1) Each prepaid limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner in a minimum of twenty-five thousand dollars ($25,000) plus twenty-five percent (25%) of the tangible net equity required in Subsection (a) of this section. The commissioner, in his discretion, may require a larger deposit than the minimum.

(2) The deposit shall be an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

(3) All income from deposits shall be an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

(4) The deposit shall be used to protect the interests of the prepaid limited health service organization_s enrollees and to assure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit shall be an asset subject to

provisions of the liquidation act.

(5) The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to such effect, authenticated by the appropriate state official holding the deposit.

(d) Upon application by a prepaid limited health service organization, the commissioner may waive some or all of the requirements of Subsection (a) of this section for any period of time the commissioner shall deem proper upon a finding that either (1) the prepaid limited health service organization has a net equity of at least five million dollars ($5,000,000); or (2) an entity having a net equity of at least five million dollars ($5,000,000) furnishes to the commissioner a written commitment, which is acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

(e) For the purposes of this section, "uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health organization (1) for which an enrollee may be liable in the event of the insolvency of the organization and (2) for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered a covered expense.

SECTION 18. Officers and employees fidelity bond.

(a) A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than the minimum specified in the most current edition of the Examiner_s Handbook of the National Association of Insurance Commissioners. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this subsection is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines agent resident in this state in

compliance with §§ 23-64-201, et seq., shall satisfy the requirements of this subsection.

(b) In lieu of the bond specified in Subsection (a) of this section, a prepaid limited health service organization may deposit with the commissioner cash or securities or other investments of the types set forth in Section 14 of this act. Such a deposit must be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a bond under this subsection.

SECTION 19. Reports.

(a) Every prepaid limited health service organization shall file with the commissioner annually, on or before March 1, a report verified by at least two (2) principal officers covering the preceding calendar year.

(b) Such report shall be on forms prescribed by the commissioner and shall include:

(1) A financial statement of the organization, including its balance sheet, income statement and statement of changes in financial position for the preceding year, certified by an independent public accountant or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which shall be consolidating financial statements of the prepaid limited health service organization;

(2) The number of subscribers at the beginning of the year, the number of subscribers as of the end of the year, and the number of enrollments terminated during the year; and

(3) Such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out his or her duties under this act.

(c) The commissioner may require more frequent reports containing such information as is necessary to enable the commissioner to carry out his or her duties under this act.

(d) The commissioner may assess a fine of up to one hundred dollars ($100) per day for each day any required report is late, and the commissioner may suspend the organization_s certificate of authority pending the proper filing of the required report by the organization.

SECTION 20. Suspension or revocation of certificate of authority.

(a) The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization pursuant to this act upon determining that any of the following conditions exist:

(1) The prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to Section 3 of this act, unless amendments to such submissions have been filed with and approved by the commissioner;

(2) The prepaid limited health service organization issues an evidence of coverage or uses rates or charges which do not comply with the requirements of Sections 8 and 9 of this act;

(3) The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services;

(4) The prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) The tangible net equity of the prepaid limited health service organization is less than that required by Section 17 or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

(6) The prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by Section 12 of this act;

(7) The continued operation of the prepaid limited health service organization would be hazardous to its enrollees;

(8) The prepaid limited health service organization has otherwise failed to comply with this act.

(b) If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he or she shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than sixty (60) days thereafter for a hearing on the matter in accordance with §§ 23-61-301, et seq.

(c) When the certificate of authority of a prepaid limited health service organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

SECTION 21. Penalties.

In lieu of any penalty specified elsewhere in this act, or when no penalty is specifically provided, whenever any prepaid limited health service organization or other person, corporation, partnership or entity subject to this act has been found, pursuant to §§ 23-61-301, et seq., §§ 23-63-501, et seq., §§ 23-69-101, et seq., §§ 23-66-201, et seq. to have violated any provision of this act, the commissioner may:

(1) Issue and cause to be served upon the organization, person, or entity charged with the violation a copy of such findings and an order requiring such organization, person, or entity to cease and desist from engaging in the act or practice which constitutes the violation; and

(2) Impose a monetary penalty of not more than one thousand ($1,000) for each violation, but not to exceed an aggregate penalty of ten thousand dollars ($10,000).

SECTION 22. Rehabilitation, conservation or liquidation.

(a) Any rehabilitation, conservation or liquidation of a prepaid limited health service organization shall be deemed to be the rehabilitation, conservation or liquidation of an insurance company and shall be conducted pursuant to §§ 23-68-101, et seq.

(b) No prepaid limited health service organization shall be subject to the laws and regulations governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to any individuals entitled to receive limited health services from a prepaid

limited health service organization.

SECTION 23. Fees.

Every prepaid limited health service organization subject to this act shall pay to the commissioner for the Arkansas Insurance Department Trust Fund fees as stated by rule and regulation. Every prepaid limited health service organization subject to this act shall also pay to the treasurer of state through the commissioner, fees, and miscellaneous charges pursuant to §§ 23-61-401 and 23-61-701, et seq.

SECTION 24. Confidentiality.

(a) Any information pertaining to the diagnosis, treatment or health of any enrollee obtained from such person or from any provider by any prepaid limited health service organization and any contract with providers submitted pursuant to the requirements of this act shall be held in confidence and shall not be disclosed to any person except:

(1) To the extent that it may be necessary to carry out the purposes of this act; or

(2) Upon the express consent of the enrollee or applicant, provider, or prepaid limited health service organization, as appropriate; or

(3) Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) In the event of claim or litigation wherein such data or information is relevant.

(b) With respect to any information pertaining to the diagnosis, treatment or health of any enrollee or applicant, a prepaid limited health service organization shall be entitled to claim any statutory privileges against disclosure which the provider who furnished such information to the prepaid limited health service organization is entitle to claim.

(c) In addition, any information provided to the commissioner that constitutes a trade secret, is privileged information, or is part of a department investigation or examination shall be held in confidence.

SECTION 25. Taxes.

The same tax rate provided for in § 23-76-131 shall be imposed upon

each prepaid limited health service organization, and such organization also shall be entitled to the same tax deductions, reductions, abatements and credits that health maintenance organizations are entitled to receive.

SECTION 26. Regulations.

The commissioner may, after notice and hearing, promulgate rules and regulations to carry out the provisions of this act.

SECTION 27. Severability.

If any section, term or provision of this act shall be adjudged invalid for any reason by a court of competent jurisdiction, such judgment shall not affect, impair or invalidate any other section, term or provision of this act, but the remaining sections, terms and provisions shall be and remain in full force and effect.

SECTION 28. All provisions of this act of a general and permanent nature are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas Code Revision Commission shall incorporate the same in the Code.

SECTION 29. All laws and parts of laws in conflict with this act are hereby repealed.

SECTION 30. Emergency. It is hereby found and determined by the General Assembly of the State of Arkansas that the present insurance laws are not sufficient to protect the Arkansas insurance-buying public. It is determined that it is in the best interests of the State of Arkansas that the laws in this act be adopted immediately so that the Arkansas Insurance Department can better regulate the insurance industry. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval.

/s/Rep. Thomas