**Stricken language would be deleted from present law. Underlined language would be added to present law.**

State of Arkansas *As Engrossed: H2/27/97*
81st General Assembly **A Bill**
Regular Session, 1997 HOUSE BILL 1715

By: Representatives Cunningham, Newman, Miller, Purdom, McGee, Wilson, Fletcher, George, Malone, and Capps

## For An Act To Be Entitled

"AN ACT TO IMPROVE PORTABILITY AND CONTINUITY OF HEALTH INSURANCE COVERAGE IN THE ARKANSAS GROUP MARKET; TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 OF THE CONGRESS OF THE UNITED STATES; AND FOR OTHER PURPOSES."

## Subtitle

"ARKANSAS HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1997."

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

SECTION 1. Chapter 86 of Title 23 of the Arkansas Code is hereby amended by inserting a new and additional subchapter 3 to read as follows:

"§23-86-301. This subchapter may be cited as the `Arkansas Health Insurance Portability and Accountability Act of 1997'.

§23-86-302. EFFECTIVE DATES. LIMITATION OF ACTIONS. APPLICABILITY.

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

(b) Determination of creditable coverage.

(1) Period of coverage. In general. Subject to subparagraph (2)(A), no period before July 1, 1996 shall be taken into account in determining creditable coverage.

(2) Certifications.

(A) In general. Subject to subparagraphs (B) and (C) below, subsection (e) of §23-86-304 shall apply to events occurring after June 30, 1996.

(B) No certification required to be provided before June 1, 1997. In no case is a certification required to be provided under such subsection before June 1, 1997.

(C) Certification only on written request for events occurring before October 1, 1996. In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual with respect to whom the certification is otherwise required to be made requests such certification in writing.

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

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

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

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

(d) Applicability. The provisions of this Act shall be applicable to all disability insurers, health maintenance organizations, hospital and medical service corporations, and fraternal benefit societies which are licensed and authorized by the Insurance Commissioner to transact business in the State of Arkansas. The provisions of this Act shall be applicable to all licensed or state regulated multiple employer welfare arrangements, licensed or state regulated health benefit plans, licensed or state regulated multiple employer trusts, or other licensed or state regulated persons providing a plan of group health insurance coverage in this State.

§23-86-303. DEFINITIONS. For purposes of this Act, the following terms are hereby defined:

(a) Affiliation Period. The term `affiliation period' means a period which, under the terms of the coverage offered by the health maintenance organization, must expire before the coverage becomes effective.

(b) Bona fide association. The term `bona fide association' means, with respect to health insurance coverage offered in Arkansas, an association which:

(1) has been actively in existence for at least 5 years;

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

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

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

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

(6) meets such additional requirements as may be imposed under Arkansas law.

(c) Church plan. The term `church plan' has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA).

(d) COBRA continuation provision. The term `COBRA continuation provision' means any of the following:

(1) Part 6 of Subtitle B of Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA), other than Section 609 of such Act;

(2) Section 4980B of the Internal Revenue Code of 1986, other than Subsection (f)(1) of such section insofar as it relates to pediatric vaccines;

(3) Title XXII of the Public Health Service Act.

(e) Commissioner or Insurance Commissioner. The terms `Commissioner' and `Insurance Commissioner' mean the Insurance Commissioner for the State of Arkansas.

(f) Creditable coverage. The term `creditable coverage' means, with

respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) Health insurance coverage;

(3) Part A or Part B of Title XVIII of the Social Security Act;

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;

(5) Chapter 55 of Title 10, United States Code;

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

(7) A State health benefits risk pool;

(8) A health plan offered under Chapter 89 of Title 5, United States Code;

(9) A public health plan as defined in regulations;

(10) A health benefit plan under Section 5(e) of the Peace Corps Act 22 U.S.C. 2504(e). Such term does not include coverage consisting solely of coverage of excepted benefits as defined in §23-86-310 of this Act.

(g) Department. The term `Department' means the Arkansas Insurance Department unless the context requires otherwise.

(h) Eligible individual defined. For purposes of this Act, the term `eligible individual' means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small group market, such an individual in relation to the employer as shall be determined:

(1) in accordance with the terms of such plan;

(2) as provided by the issuer under rules of the issuer which are uniformly applicable in Arkansas to small employers in the small group market; and

(3) in accordance with all applicable Arkansas law governing such issuer and such market.

(i) Employee. The term `employee' has the meaning given such term under Section 3(6) of the Employee Retirement Income Security Act of 1974.

(j) Employer. The term `employer' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (ERISA), except that such term shall include only employers of two or more employees.

(k) Employer Contribution Rule. The term `employer contribution rule' means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

(l) Enrollment date. The term `enrollment date' means, with respect to an individual covered under a group health plan or health insurance coverage, the date of coverage of the individual in the plan or, if earlier, the first day of the waiting period for such coverage.

(m) Federal governmental plan. The term `Federal governmental plan' means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(n) Governmental plan. The term `governmental plan' has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) and any Federal governmental plan.

(o) Group health insurance coverage. The term `group health insurance coverage' means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(p) Group Health Plan. The term `group health plan' means an employee welfare benefit plan to the extent that the plan provides medical care, as defined in this Section and including items and services paid for as medical care, to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(q) Group Participation Rule. The term `group participation rule' means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(r) Health insurance coverage. The term `health insurance coverage' means benefits consisting of medical care, provided directly, through insurance or reimbursement or otherwise and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(s) Health insurance issuer. The term `health insurance issuer' means an insurance company, insurance service, or insurance organization including a health maintenance organization as defined in this Section which is licensed

to engage in the business of insurance in a State and which is subject to Arkansas law which regulates insurance. Such term does not include a group health plan.

(t) Health maintenance organization. The term `health maintenance organization' means:

(1) a federally qualified health maintenance organization as defined in Section 1301(a) of the Public Health Service Act, 42 U.S.C. 300e(a);

(2) an organization recognized under State law as a health maintenance organization; or

(3) a similar organization regulated under State law for solvency in the same manner and to the same extent as a health maintenance organization.

(u) Health status-related factor. The term `health status-related factor' means any of the factors described in §23-86-306(a)(1).

(v) Individual Market. In general. The term `individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(w) Large employer. The term `large employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(x) Large group market. The term `large group market' means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a large employer.

(y) Late enrollee. The term `late enrollee' means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan, or

(2) a special enrollment period under subsection (f) of §23-86-304 of this Act.

(z) Medical care. The term `medical care' means amounts paid for, or services provided for:

(1) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) amounts paid for transportation primarily for and essential to medical care referred to in paragraph (1); and

(3) amounts paid for insurance covering medical care referred to in paragraphs (1) and (2).

(aa) Network plan. The term `network plan' means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(bb) Non-Federal governmental plan. The term `non-Federal governmental plan' means a governmental plan that is not a Federal governmental plan.

(cc) Participant. The term `participant' has the meaning given such term under Section 3(7) of the Employee Retirement Income Security Act of 1974 (ERISA).

(dd) Placed for adoption. The term `placement', or being `placed', for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(ee) Plan sponsor. The term `plan sponsor' has the meaning given such term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (ERISA).

(ff) Preexisting condition exclusion. The term `preexisting condition exclusion' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(gg) Regulations. The term `regulations' means rules and regulations promulgated by the Insurance Commissioner unless the context requires otherwise.

(hh) Small employer. The term `small employer' means, in connection

with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(ii) Small group market. The term `small group market' means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a small employer.

(jj) State. The term `State' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(kk) State law. The term `State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

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

§23-86-304. INCREASED PORTABILITY THROUGH LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

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

(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

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

(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage if any, as

defined in subsection (c)(1) below, applicable to the participant or beneficiary as of the enrollment date.

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

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

(1) Not counting periods before significant breaks in coverage.

(A) In general. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage. For purposes of paragraph (A) immediately above, and subsection (d)(4) of this Section, any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period as defined in subsection (1) of §23-86-303 of this Act shall not be taken into account in determining the continuous period under paragraph (A).

(2) Method of crediting coverage.

(A) Standard method. Except as otherwise provided under paragraph (B) below, for purposes of applying subsection (a)(3) of this Section, a group health plan and a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) Election of alternative method. A group health plan or a health insurance issuer offering group health insurance coverage may elect to apply subsection (a)(3) of this Section based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under paragraph (A) immediately above. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice. In the case of an election with respect

to a group health plan under subparagraph (B) immediately above, whether or not health insurance coverage is provided in connection with such plan, the plan shall:

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

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

(D) Issuer notice. In the case of an election under paragraph (B) above with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer:

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

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

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

(d) Exceptions.

(1) Exclusion not applicable to certain newborns. Subject to subdivision (4) below, a group health plan and a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. Subject to subdivision (4) below, a group health plan and a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence in this subdivision shall not apply to coverage before the date of such adoption or placement for adoption.

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

(4) Loss if break in coverage. Subdivisions (1) and (2) above shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and Disclosure of Coverage.

(1) Requirement for certification of period of creditable coverage.

(A) In general. A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in paragraph (B) below:

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision; and

(iii) at the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in subparagraph (i) or (ii) above, whichever is later. The certification under subparagraph (i) above may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

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

(i) the period of creditable coverage of the individual under such plan and the coverage, if any, under such COBRA continuation provision; and

(ii) the waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance. To the extent that medical care under a group health plan consists of group health insurance coverage, the

plan is deemed to have satisfied the certification requirement under this subdivision if the health insurance issuer offering the coverage provides for such certification in accordance with this subdivision.

(2) Disclosure of information on previous benefits. In the case of an election described in subsection (c)(2)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subdivision (1):

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

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

(f) Special Enrollment Periods.

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

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

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

(C) The employee's or dependent's coverage described in paragraph (A) above:

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the

coverage was terminated as a result of loss of eligibility for the coverage including loss as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions toward such coverage were terminated; and

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

(2) For dependent beneficiaries.

(A) In general. If:

(i) a group health plan makes coverage available with respect to a dependent of an individual;

(ii) the individual is a participant under the plan or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for that individual's failure to enroll during a previous enrollment period; and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, *then the enrollment period described in paragraph (B) below shall be provided, during which the person (or,* if not otherwise enrolled, the *individual) may* be enrolled under the plan as a dependent of the individual; and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period. A dependent special enrollment period under paragraph (A) above shall be a period of not less than 30 days and shall begin on the later of:

(i) the date dependent coverage is made available; or

(ii) the date of the marriage, birth, or adoption or placement for adoption as the case may be described in paragraph (A)(iii) above.

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

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for

enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(g) Use of Affiliation Period by HMO's as Alternative to Preexisting Condition Exclusion.

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

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

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

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

(2) Affiliation period.

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

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

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

(3) Alternative methods. A health maintenance organization described in subsection (g)(1) above may use alternative methods, from those described in such subdivision, to address adverse selection as approved by the Insurance Commissioner.

§23-86-305. GROUP HEALTH PLAN.

Application of certain rules in determination of employer size.

(1) Application of aggregation rule for employers. All persons treated as a single employer under Subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one (1) employer;

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

(3) Predecessors. Any reference in this subsection to an employer shall include a reference to any predecessor of such employer."

§23-86-306. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

(a) In Eligibility To Enroll.

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

(A) Health status;

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

(C) Claims experience;

(D) Receipt of health care;

(E) Medical history;

(F) Genetic information;

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

(H) Disability.

(2) No application to benefits or exclusions. To the extent consistent with §23-86-304, subdivision (1) of this subsection shall not be construed:

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

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

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

(b) In Premium Contributions.

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

(2) Construction. Nothing in subsection (b)(1) above shall be construed:

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

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

§23-86-307. GUARANTEED RENEWABILITY IN MULTIEMPLOYER PLANS AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (`MEWA's').

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

(a) for nonpayment of contributions;

(b) for fraud or other intentional misrepresentation of material fact by the employer;

(c) for noncompliance with material plan provisions;

(d) because the plan is ceasing to offer any coverage in a geographic area;

(e) in the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies

this paragraph uniformly without regard to the claims experience of employers or any health status-related factor in relation to such individuals or their dependents; and

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

§23-86-308. RULES OF CONSTRUCTION. Nothing in this Act shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

§23-86-309. SPECIAL RULES RELATING TO GROUP HEALTH PLANS.

(a) General Exception for Certain Small Group Health Plans. The requirements of this Act shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

(b) Exception for Certain Benefits. The requirements of this Act shall not apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in §23-86-310(a).

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

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

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

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

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

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

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

by the same plan sponsor; and

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

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

(d) Treatment of Partnerships.

(1) Treatment as a group health plan. Any plan, fund, or program which would not be, but for this subsection, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents, as defined under the terms of the plan, fund, or program) directly or through insurance or reimbursement or otherwise, shall be treated, subject to subdivision (2) below as an employee welfare benefit plan which is a group health plan.

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

(3) Participants of group health plans. In the case of a group health plan, the term `participant' also includes:

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

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

§23-86-310. EXCEPTED BENEFITS. For purposes of this section, the term `excepted benefits' means benefits under one or more, or any combination thereof, of the following:

(a) Benefits not subject to requirements:

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

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

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

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for on-site medical clinics;

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

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

(1) Limited scope dental or vision benefits;

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

(3) Such other similar, limited benefits as specified in regulations.

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

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

(2) Hospital indemnity or other fixed indemnity insurance.

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

§23-86-311. GUARANTEED RENEWABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET.

(a) In General. Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force such coverage at the option of the plan sponsor of the plan.

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

(1) Nonpayment of premiums. The plan sponsor has failed to pay

premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

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

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

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

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

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

(c) Requirements for Uniform Termination of Coverage.

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

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

days prior to the date of the discontinuation of such coverage;

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

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

(2) Discontinuance of all coverage.

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

(i) the issuer provides notice to the commissioner and to each plan sponsor and participants and beneficiaries covered under such coverage of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

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

(B) Prohibition on market reentry. In the case of a discontinuation under paragraph (A) above in a market, the issuer may not provide for the issuance of any health insurance coverage in the market in this State during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

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

(1) in the large group market; or

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

basis among group health plans with that product.

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

§23-86-312. GUARANTEED AVAILABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET.

(a) Issuance of Coverage in the Small Group Market.

In general. Subject to subsections (b) through (e) of this Section, each health insurance issuer that offers health insurance coverage in the small group market in Arkansas:

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

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

(b) Special Rules for Network Plans.

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

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

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

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

(ii) it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their

employees and their dependents or any health status-related factor relating to such employees and dependents.

(2) 180-day suspension upon denial of coverage. An issuer, upon denying health insurance coverage in any service area in accordance with subdivision (1)(B) above, may not offer coverage in the small group market within such service area in this State for a period of 180 days after the date such coverage is denied.

(c) Application of Financial Capacity Limits.

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

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

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

(2) 180-day suspension upon denial of coverage. A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with subdivision (1) above in Arkansas may not offer coverage in connection with group health plans in the small group market in this State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the commissioner that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. The commissioner may provide for the application of this subsection on a service-area-specific basis.

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

(e) Exception for Coverage Offered Only to Bona Fide Association Members. Subsection (a) of this Section shall not apply to health insurance coverage offered by a health insurance issuer if such coverage is made

available in the small group market only through one or more bona fide associations as defined in §23-86-303(b).

§23-86-313. DISCLOSURE OF INFORMATION.

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

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

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

(b) Information Described.

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

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

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

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

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

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

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

§23-86-314. EXCLUSION OF CERTAIN PLANS.

(a) Exception for Certain Small Group Health Plans. The requirements of §§23-86-304 (Limitation on Preexisting Conditions), 306 (Prohibiting Discrimination Based on Health Status), 311 (Guaranteed Renewability), 312

(Guaranteed Availability)and 313 (Disclosure of Information) of this Act shall not apply to any group health plan and health insurance coverage offered in connection with a group health plan for any plan year if, on the first day of such plan year, such plan has less than two (2) participants who are current employees.

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

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

(A) subject to subdivision (2) below, in the case of a plan that is a nonfederal governmental plan, and

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

(2) Treatment of nonfederal governmental plans.

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

(B) Period of election. An election under subdivision (A) shall apply:

(i) for a single specified plan year; or

(ii) in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement. An election under paragraph (i) may be extended through subsequent elections under this paragraph.

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

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

(ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with

§23-86-304(e).

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

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

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

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

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

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

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

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

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

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

SECTION 2. 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 3. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

SECTION 4. All laws and parts of laws in conflict with this act are hereby repealed.

SECTION 5. EMERGENCY. It is hereby found and determined by the General Assembly that the passage of the Health Insurance Portability and Accountability Act of 1996 by the Congress of the United States now requires amendments to existing Arkansas laws on health insurance to ensure conformity with this new Federal law. It is hereby found and determined that in this respect the present insurance laws of the State of Arkansas are not sufficient to protect the insurance buying public. It is determined that it is in the best interests of the State of Arkansas that the provisions of this Act be adopted immediately so that health insurers, HMO's and others shall have additional time to prepare to comply fully with the new Federal law as required no later than June 30, 1997. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.

*/s/Rep. Cunningham et al*