ExamFX

Addendum: for use with Arkansas Life and Health online courses and study guide, version number 27274en/27276en, per exam content outline updates effective 3/1/2023.

Effective March 1, 2023, Arkansas is adopting PSI's national outline for the General Knowledge portion of the exam. The course layout, chapter titles, and the Exam Breakdown will be updated to match the new outline.

*The following are **content additions** to supplement your existing text unless otherwise indicated. The additions below are referenced under new content domains.*

LIFE AND HEALTH:

Introduction — *Revised exam breakdowns*

Arkansas Life Insurance Examination
110 Total Questions (100 scored, 10 pretest)

CHAPTERS	PERCENTAGE OF EXAM
General Knowledge:	
General Insurance Concepts	11%
Life Insurance Basics	13%
Types of Life Insurance Policies	14%
Life Policy Provisions, Riders and Options	20%
Annuities	8%
Federal Tax Considerations for Life Insurance	4%
State Law:	
Arkansas Statutes, Rules, and Regulations Common to Life and Health Insurance	20%
Arkansas Statutes and Rules Pertinent to Life Insurance Only	10%

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Arkansas Health Insurance
110 Total Questions (100 scored, 10 pretest)

CHAPTERS	PERCENTAGE OF EXAM
General Knowledge:	
General Insurance Concepts	10%
Accidental and Health Insurance Basics	13%
Individual Accidental and Health Insurance Policy Provisions	12%
Disability Income and Related Insurance	7%
Medical Plans	15%
Group Health Insurance	4%
Specialized Health Insurance for Qualified Individuals	6%
Federal Tax Considerations for Health Insurance	3%
State Law:	
Arkansas Statutes, Rules, and Regulations Common to Life and Health Insurance	20%
Arkansas Laws, Rules, and Regulations Pertinent to Health Insurance Only	10%

General Insurance Concepts

Risk

1. Definitions

Risk is the uncertainty or chance of a loss occurring. The two types of risks are pure and speculative, only one of which is insurable.

- **Pure risk** refers to situations that can only result in a loss or no change. There is no opportunity for financial gain. Pure risk is the only type of risk that insurance companies are willing to accept.
- **Speculative risk** involves the opportunity for either loss or gain. An example of speculative risk is gambling. These types of risks are not insurable.

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Hazards are conditions or situations that increase the probability of an insured loss occurring. Hazards are classified as physical hazards, moral hazards, or morale hazards. Conditions such as lifestyle and existing health, or activities such as scuba diving, are hazards and may increase the chance of a loss occurring.

Physical hazards are individual characteristics that increase the chances of the cause of loss. Physical hazards exist because of a physical condition, past medical history, or a condition at birth, such as blindness.

Moral hazards are tendencies towards increased risk. Moral hazards involve evaluating the character and reputation of the proposed insured. Moral hazards refer to those applicants who may lie on an application for insurance, or in the past, have submitted fraudulent claims against an insurer.

Morale hazards are similar to moral hazards, except that they arise from a state of mind that causes indifference to loss, such as carelessness. Actions taken without forethought may cause physical injuries.

Perils are the **causes** of loss insured against in an insurance policy. *Life insurance* insures against the financial loss caused by the premature death of the insured.

Loss is defined as the reduction, decrease, or disappearance of value of the person or property insured in a policy, caused by a named peril. Insurance provides a means to transfer loss.

2. Elements of Insurable Risks

Not all risks are insurable. As noted earlier, insurers will insure only **pure risks,** or those that involve only the chance of loss with no chance of gain. Furthermore, even pure risks must have certain characteristics in order to be insurable. Insurable risks involve the following characteristics:

- **Due to chance —** A loss that is outside the insured’s control.
- **Definite and measurable —** A loss that is specific as to the cause, time, place and amount. An insurer must be able to determine how much the benefit will be and when it becomes payable.

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- **Statistically predictable —** Insurers must be able to estimate the average frequency and severity of future losses and set appropriate premium rates. (In life and health insurance, the use of mortality tables and morbidity tables allows the insurer to project losses based on statistics.)
- **Not catastrophic —** Insurers need to be reasonably certain their losses will not exceed specific limits. That is why insurance policies usually exclude coverage for loss caused by war or nuclear events: There is no statistical data that allows for the development of rates that would be necessary to cover losses from events of this nature.
- **Randomly selected and large loss exposure —** There must be a sufficiently large pool of the insured that represents a random selection of risks in terms of age, gender, occupation, health and economic status, and geographic location.

3. Methods of Handling Risk

Avoidance

One of the methods of dealing with risk is **avoidance**, which means eliminating exposure to a loss. *For example,* if a person wanted to avoid the risk of being killed in an airplane crash, he/she might choose never to fly in an airplane. Risk avoidance is effective, but seldom practical.

Retention

Risk **retention** is the planned assumption of risk by an insured through the use of deductibles, co-payments, or self-insurance. It is also known as self-insurance when the insured accepts the responsibility for the loss before the insurance company pays. The purpose of retention is

- To reduce expenses and improve cash flow;
- To increase control of claim reserving and claims settlements; and
- To fund for losses that cannot be insured.

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Sharing

Sharing is a method of dealing with risk for a group of individual persons or businesses with the same or similar exposure to loss to share the losses that occur within that group. A reciprocal insurance exchange is a formal risk-sharing arrangement.

Reduction

Since we usually cannot avoid risk entirely, we often attempt to lessen the possibility or severity of a loss. **Reduction** would include actions such as installing smoke detectors in our homes, having an annual physical to detect health problems early, or perhaps making a change in our lifestyles.

Transfer

The most effective way to handle risk is to **transfer** it so that the loss is borne by another party. Insurance is the most common method of transferring risk from an individual or group to an insurance company. Though the purchasing of insurance will not eliminate the risk of death or illness, it relieves the insured of the financial losses these risks bring.

Authority and Powers of Producers

An agent/producer is an individual licensed to sell, solicit or negotiate insurance contracts on behalf of the **principal (insurer).** The **law of agency** defines the relationship between the principal and the agent/producer: the acts of the agent/producer within the scope of authority are deemed to be the acts of the insurer.

In this relationship, it is a given that

- An agent represents the insurer, not the insured;
- Any knowledge of the agent is presumed to be knowledge of the insurer;
- If the agent is working within the conditions of his/her contract, the insurer is fully responsible; and
- When the insured submits payment to the agent, it is the same as submitting a payment to the insurer.

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The agent is responsible for accurately completing applications for insurance, submitting the application to the insurer for underwriting, and delivering the policy to the policyowner.

The agency contract details the authority an agent has within his/her company. Contractually, only those actions that the agent is authorized to perform can bind the principal (insurer). In reality, an agent's authority is much broader. There are 3 types of agent authority: express, implied, and apparent.

Express authority is the authority a principal intends to grant to an agent by means of the agent’s contract. It is the authority that is written in the contract.

Implied authority is authority that is **not expressed or written into the contract, but which the agent is assumed to have in order to transact the business** of insurance for the principal. Implied authority is incidental to and derives from express authority since not every single detail of an agent’s authority can be spelled out in the written contract.

Apparent authority (also known as *perceived* authority) is the appearance or the assumption of authority based on the actions, words, or deeds of the principal or because of circumstances the principal created. *For example,* if an agent uses insurer's stationery when soliciting coverage, an applicant may believe that the agent is authorized to transact insurance on behalf of the insurer.

Legal Interpretations Affecting Contracts

1. Reasonable Expectations

It is not always practical or necessary to state every direct and indirect provision or coverage offered by an insurance policy. If an agent implies through advertising, sales literature or statements that these provisions exist, an insured could **reasonably expect coverage**.

2. Indemnity

Indemnity (sometimes referred to as **reimbursement**) is a provision in an insurance policy that states that in the event of loss, an insured or a beneficiary is permitted to collect only to the extent of the financial loss, and is

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not allowed to gain financially because of the existence of an insurance contract. The purpose of insurance is to restore, but not let an insured or a beneficiary profit from the loss.

3. Utmost Good Faith

The principle of **utmost good faith** implies that there will be no fraud, misrepresentation or concealment between the parties. As it pertains to insurance policies, both the insurer and insured must be able to rely on the other for relevant information. The insured is expected to provide accurate information on the application for insurance, and the insurer must clearly and truthfully describe policy features and benefits, and must not conceal or mislead the insured.

4. Fraud

Fraud is the intentional misrepresentation or intentional concealment of a material fact used to induce another party to make or refrain from making a contract, or to deceive or cheat a party. Fraud is grounds for voiding an insurance contract.

Federal Laws and Regulations

Prohibited Persons in Insurance Waiver (18 USC Sections 1033 and 1034)

It is considered **unlawful insurance fraud** for any person engaged in the business of insurance to willfully, and with the intent to deceive, make any oral or written statement that are either false or omit material facts. This includes information and statements made on an application for insurance, renewal of a policy, claims for payment or benefits, premiums paid, and financial condition of an insurer.

Anyone engaged in the business of insurance whose activities affect interstate commerce, and who knowingly makes false material statements may be fined, imprisoned for up to **10 years** or both. If the activity jeopardized the security of the accompanied insurer, the punishment can be up to **15 years**.

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Anyone acting as an officer, director, agent or other insurance employee who is convicted of embezzling funds faces the aforementioned fines and imprisonment. However, if the embezzlement was in an amount less than **$5,000**, prison time may be reduced to 1 year.

Federal law makes it illegal for any individual convicted of a crime involving dishonesty, breach of trust or a violation of the **Violent Crime Control and Law Enforcement Act of 1994** to work in the business of insurance affecting interstate commerce without receiving a **letter of written consent** from an insurance regulatory official — a **1033 waiver**. The consent of the official must specify that it is granted for the purpose of 18 U.S.C. 1033. Anyone convicted of a felony involving dishonesty or breach of trust, who also engages in the business of insurance, will be fined, imprisoned for up to 5 years or both.

Section 1034, Civil Penalties and Injunctions for Violations of Section 1033, states that the Attorney General may bring a **civil action** in the appropriate U.S. district court against any person who engages in conduct that is in violation of Section 1033 of not more than **$50,000** for each violation, or the amount of compensation the person received as a result of the prohibited conduct, whichever is greater.

National Do Not Call List

In 2003, the Federal Trade Commission (FTC) and the Federal Communications Commission (FCC) worked together to create the **National Do Not Call Registry**, allowing consumers to include their telephone numbers on the list to which solicitation calls cannot be made by telemarketers. Insurance companies need to comply with this regulation when making solicitation phone calls.

To comply with the telemarketing sales rules, telemarketers must not do any of the following:

- Call any number on the National Do Not Call Registry or on that seller's Do Not Call list;
- Deny someone a right to be placed on any Do Not Call Registry;
- Call outside permissible calling hours (before 8 a.m. and after 9 p.m.);
- Abandon calls;
- Fail to transmit caller ID information;

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- Threaten or intimidate a consumer or use obscene language; or
- Cause any telephone to ring or engage a person in conversation with the intent to annoy, abuse, or harass the person called.

Some **exceptions** to the Do Not Call Registry include the following calls:

- From or on behalf of organizations which have established a business relationship with the consumer (for the last 18 months from the date of a sale or transaction);
- For which the consumer has given prior written permission;
- Not commercial or that do not include unsolicited advertisements; and
- By or on behalf of tax-exempt nonprofit organizations.

To keep in compliance with the Do Not Call rules, organizations must consult the registry every **31 days.** Any phone numbers on the registry must be dropped from the organization's call lists.

CAN-SPAM Act

CAN-SPAM legislation was established to set the rules for commercial e-mail, and to give recipients the right to reject commercial messages. CAN-SPAM covers all commercial electronic messages, including business-to-business messages, the purpose of which is the commercial advertisement or promotion of a product or service.

CAN-SPAM requires that any commercial email must contain an opt-out mechanism; all opt-out requests must be honored within **10 business days**. To be in compliance with this legislation, the entity that sends out e-mails must do the following:

- Make sure that the advertiser is identified in the *from* line;
- Not use misleading subject lines;
- Include an opt-out mechanism and honor all opt-out requests within 10 days;
- Include the advertiser's valid physical postal address; and
- If the message is unsolicited, it must be identified as an *advertisement* somewhere in the e-mail.

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Each violation of the above provisions is subject to fines of up to $16,000. On top of that is a penalty of $250 per each noncompliant e-mail, with a cap of $2 million dollars.

LIFE ONLY:

Life Insurance Basics

Determining Amount of Personal Life Insurance

Individuals seeking to buy life insurance may need assistance trying to establish how much coverage is appropriate, based on their ability to pay the premium, serve their needs, and protect their survivors. Insurance companies have developed 2 basic approaches to help producers and buyers to determine the needed amount of protection: human life value approach and needs approach.

1. Human Life Value Approach

The **human life value approach (HLVA)** gives the insured an estimate of what would be lost to the family in the event of the premature death of the insured. It calculates an individual's life value by looking at the insured's wages, inflation, the number of years to retirement, and the time value of money.

2. Needs Approach

The needs approach is based on the predicted **needs of a family** after the premature death of the insured. Some of the factors considered by the needs approach are income, the amount of debt (including mortgage), investments, and other ongoing expenses.

Planning for Income Needs

Besides taking care of immediate expenses after the death of the insured, the family may need to plan for an income source long term, so the needs approach to life insurance will factor in the following concerns:

- **Replacing Insured's Salary or Lost Services** — the surviving spouse who was the caregiver of the children may have to train to enter the job market. If the spouse works outside the home, a new expense for day care must be considered.

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- **Social Security Income "Blackout" Period** — Social Security blackout period is the time during which the surviving spouse and/or children do not receive any social security survivor benefits. Blackout period begins when the youngest child reaches the age of 16, and ends when the surviving spouse qualifies for retirement benefits, as early as age 60.
- **Liquidation vs. Retention of Capital** — Under the retention of capital approach, enough insurance is purchased so that when added to other liquid assets, there is enough to pay income benefits without jeopardizing the insured's principal asset (such as a home).

Business Uses of Life Insurance

1. Executive Bonuses

Executive bonus is an arrangement where the employer offers to give the employee a wage increase in the amount of the premium on a new life insurance policy on the employee. The employee owns the policy and, therefore, has full rights to the policy. Since the employer treated the premium payment as a bonus, that amount is **tax deductible to the employer** and **income taxable to the employee**. It is assumed that if the employee were not willing to accept these conditions, the employer would not provide the benefit. Executive bonus plans are not subject to plan limits established by the IRS for qualified plans, so it is considered a nonqualified benefit plan.

Annuities

Uses of Annuities

The principal use of an annuity is to provide income for **retirement**; however, an annuity may be used for any accumulation of cash or simply to liquidate an estate. Because of the various uses of annuities, agents should always assess how well a recommended product will meet the applicant's needs and resources — the **suitability** of a product.

1. Lump-Sum Settlements

Annuities may serve as an ideal financial vehicle for someone who comes into a large lump sum of money, such as inheritance, lottery, award of damages from a lawsuit, proceeds from a sale of a business, or a lump-sum distribution from a qualified pension plan. In this case, a person may

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purchase a **single premium immediate annuity**, which will convert the lump sum into a series of periodic payments, providing a stream of income for the annuitant.

2. Retirement Income

Since annuities are a popular means to provide retirement income, they are often used to fund **qualified retirement plans**, which means they meet the IRS guidelines to receive favorable tax treatment.

3. Long-Term Care

Under the Pension Protection Act of 2006, annuitants are allowed to transfer money from an annuity to pay for long-term care insurance premiums, tax free. In the past, distributions from nonqualified annuities were taxed; however, now, distributions can be used to pay for long-term care premiums and, in many cases, eliminate the taxes on the annuity gains. As a result, many insurers now offer a hybrid annuity with a long-term care feature. These policies provide for income, long-term care, or both.

4. Guaranteed Minimum Withdrawal Benefit (GMWB)

Similar to the Guaranteed Minimum Withdrawal Benefit option, the **Guaranteed Living Benefit Rider** assures that the annuitant will receive at least the amount of money invested or a certain amount of income, usually up to the annuity purchase amount, regardless of market conditions. For that reason, this rider is generally offered to variable annuity investors where the value of the account depends solely upon the investment returns in the portfolio mutual funds.

Often, this rider can be exercised only after a certain time period (e.g., after 10 years), and there is usually a fee for the rider that can range from .25% to 1% of the contract value annually.

The rider is generally not applicable if the contract is surrendered, and withdrawals are subtracted from the account value on a dollar-for-dollar basis.

Each company's rider functions in a different manner and it is important to understand the features of the product being offered.

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HEALTH ONLY:

Individual Accident and Health Insurance Policy Provisions

Uniform Optional Provisions

1. Intoxicants and Narcotics

The insurer is not liable for any claims that result while the insured is intoxicated or under the influence of drugs (unless administered by a physician). Treatment for substance abuse is usually a covered benefit under health insurance policies. This provision simply excludes any injury or sickness that results from the insured's intoxication.

Disability Income and Related Insurance

Provisions Affecting Income Benefits

1. Cost of Living Adjustment (COLA) Rider

The purchasing power of disability benefits can be eroded by inflation. The cost of living adjustment (COLA) rider will help protect against inflation. Under this rider the insured's monthly benefit will be increased automatically, once claim payments have begun. Generally, the first increase would be at the end of one year to be followed by annual increases for as long as the insured remains on the claim. Some of these riders provide for compound interest adjustments while others provide simple interest adjustments.

Medical Plans

Cost Containment in Health Care Delivery

With the dramatic rise in the cost of medical care over the past few decades, the concept of **managed care** has become a necessity for insurance companies. Managed care plans, such as HMOs and PPOs, are designed to control costs by controlling the behavior of the plan participants.

1. Cost-Saving Services

Cost-saving services or case-management provisions provide plans with controlled access of providers, large claim management, preventive care, hospitalization alternatives, second surgical opinions, preadmission testing, catastrophic case management, risk sharing, and providing high quality of care. Insurance companies use the services of case managers for large,

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ongoing claims through a process of utilization management. The case manager evaluates the appropriateness, necessity, and quality of health care, and may include prospective and concurrent review.

Preventive Care

Managed care plans encourage preventive care and living a healthier lifestyle. Annual physical exams, mammograms, and other procedures used to detect medical problems before symptoms appear can result in a considerable cost savings if a problem is detected early and treated quickly.

Hospital Outpatient Benefits

Because hospital confinement has become so costly, many plans require the patient to take advantage of outpatient services when possible.

Alternatives to Hospital Services

Alternatives to hospital care might include home health care where the patient stays at home and is visited periodically by a health professional. A home health aide that could work in conjunction with a family member may meet daily needs. Terminally ill patients may elect hospice care rather than a hospital stay. Hospice attends to the patient's daily needs and provides pain relief but attempts no curative procedures. Within cost containment, painkillers and special hospital beds are paid for, but operations or antibiotics are not.

Preauthorization and Second Opinion

Preauthorization is a cost-containment measure requiring that the insured obtain approval from the insurer before getting an expensive surgery, referred to a specialist, or nonemergency healthcare service.

A **second opinion** is a separate assessment of a patient by a different medical professional who will then affirm or modify the patient's diagnosis and treatment plan.

2. Utilization Management

Utilization management is a system for reviewing the appropriateness and efficient allocation of health care services and resources that are being given

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or are proposed to be given to an insured. It also covers the review of claims for services that may be covered by a health care provider. There are different types of utilization management reviews: prospective, retrospective, and concurrent review.

Prospective Review

Under the **prospective review** or **precertification process**, the physician can submit claim information prior to providing treatment to know in advance if the procedure is covered under the insured's plan and at what rate it will be paid.

Concurrent Review

Under the **concurrent review** process, the insurance company will monitor the insured's hospital stay to make sure that everything is proceeding according to schedule and that the insured will be released from the hospital as planned.

HIPAA (Health Insurance Portability and Accountability Act) Requirements

Legislation that took effect in July 1997 ensures "**portability**" of group insurance coverage and includes various required benefits that affect small employers, the self-employed, pregnant women, and the mentally ill. HIPAA (Health Insurance Portability and Accountability Act) regulates protection for both **group health plans** (for employers with 2 or more employees) and for **individual insurance policies** sold by insurance companies.

HIPAA includes the following protection for coverage:

- **Group Health Plans:**
  - Prohibiting discrimination against employees and dependents based on their health condition; and
  - Allowing opportunities to enroll in a new plan to individuals in special circumstances.
- **Individual Policies:**
  - Guaranteeing access to individual policies for qualifying individuals; and
  - Guaranteeing renewability of individual policies.

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Eligibility

HIPAA has regulations regarding eligibility for employer-sponsored group health plans. These plans cannot establish eligibility rules for enrollment under the plan that discriminate based on any health factor relating to an eligible individual or the individual's dependents. A **health factor** includes any of the following:

- Health status;
- Medical conditions (both physical and mental);
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Disability; or
- Evidence of insurability, which includes conditions arising out of acts of domestic violence and participation in such activities as motorcycling, skiing, or snowmobiling.

Employer-sponsored group health plans may apply waiting periods prior to enrollment as long as they are applied uniformly to all participants.

To be eligible under HIPAA regulations to convert health insurance coverage from a **group plan** to an **individual policy**, an individual must meet the following criteria:

- Have 18 months of continuous creditable health coverage;
- Have been covered under a group plan in most recent insurance;
- Have used up any COBRA or state continuation coverage;
- Not be eligible for Medicare or Medicaid;
- Not have any other health insurance; and
- Apply for individual health insurance within 63 days of losing prior coverage.

Such HIPAA-eligible individuals are guaranteed the right to purchase individual coverage.

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Guaranteed Issue

If the new employee meets the requirements, the employer must offer coverage on a guaranteed issue basis.

Renewability

At the plan sponsor's option, the issuer offering group health coverage must renew or continue in force the current coverage. However, the group health coverage may be discontinued or nonrenewed because of nonpayment of premium, fraud, violation of participation or contribution rules, discontinuation of that particular coverage, or movement outside the service area or association membership cessation.

Federal Tax Considerations for Accident and Health Insurance

Consumer Driven Health Plans

1. Health Reimbursement Account (HRAs)

Health Reimbursement Accounts (HRAs) consist of funds set aside by employers to reimburse employees for qualified medical expenses, such as deductibles or coinsurance amounts. Employers qualify for preferential tax treatment of funds placed in an HRA in the same way that they qualify for tax advantages by funding an insurance plan. Employers can deduct the cost of a health reimbursement account as a business expense.

The following are key characteristics of HRAs:

- They are contribution healthcare plans, not defined benefit plans;
- Not a taxable employee benefit;
- Employers' contributions are tax deductible;
- Employees can roll over unused balances at the end of the year;
- Employers do not need to advance claims payments to employees or healthcare providers during the early months of the plan year;
- Provided with employer dollars, not employee salary reductions;
- Permit the employer to reduce health plan costs by coupling the HRA with a high-deductible (and usually lower-cost) health plan; and
- Balance the group purchasing power of larger employers and smaller employers.

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In **Health Reimbursement Accounts (HRAs)**, the employer's contribution is tax deductible in the year in which the reimbursement is made to the employee. The employee is not taxed on receipt of the benefit. Benefits must be paid solely to the employee for medical care expenses for the employee, the employee's spouse or dependents. If funds are distributed for other than medical care expenses, the benefit is considered to be taxable income to the employee.

Arkansas Statutes, Rules, and Regulations Pertinent to Health Only

A. Policy Provisions

1. Policy Requirements — *section expanded as follows*:

An **individual health benefit plan** must be renewable at the option of the insured, except for:

- Nonpayment of premium;
- Fraud or intentional misrepresentation by the insured;
- An insured no longer resides, lives, or works in the service area for which the insurer is authorized to do business;
- Election by the insurer to nonrenew a particular or all health benefit plans delivered or issued to individuals in Arkansas; and/or
- Individual termination of membership in an association receiving coverage.

If an insurer elects to **discontinue** offering a particular health benefit plan, it must provide notice of discontinuation to all affected insureds at least **90 calendar days** prior to the date the health benefit plan will be discontinued by the carrier. Insurers must offer the insureds the option to purchase other health benefit plans on a guaranteed issue basis. The decision to discontinue cannot be on the basis of any health-related factor of an insured.

If an insurer elects to **nonrenew all of its health benefit plans**, the insurer is required to provide advance notice of its decision to the Commissioner and all affected insureds at least **180 calendar days** prior to nonrenewal.

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An insurer that elects not to renew a health benefit plan will be prohibited from writing new business in the individual market in this state for a period of **5 years** from the date of discontinuation.

An insurer is not prohibited from modifying coverage at the time of coverage renewal, as long as the modification is consistent with state law and is made on a uniform basis among all insureds covered under a similar policy.

B. Medicare Supplement

2. Provisions — *section expanded as follows*:

Medicare supplement policies or certificates in force in Arkansas may not contain benefits that duplicate benefits provided by Medicare.

Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than **6 months** from the effective date of coverage because it involved a pre-existing condition. The policy cannot define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

The Commissioner may issue reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies. These standards will be in addition to and in accordance with applicable laws of Arkansas. No requirement of Arkansas law relating to minimum required policy benefits, other than the minimum standards provided below, apply to Medicare supplement policies and certificates. The standards may cover, but not be limited to:

- Terms of renewability;
- Initial and subsequent conditions of eligibility;
- Nonduplication of coverage;
- Probationary periods;
- Benefit limitations, exceptions, and reductions;
- Elimination periods;
- Requirements for replacement;
- Recurrent conditions; and
- Definition of terms.

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The Commissioner will issue reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies.

The Commissioner may issue reasonable regulations necessary to conform Medicare supplement policies to the requirements of federal law, including, but not limited to:

- Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;
- Establishing a uniform methodology for calculating and reporting loss ratios;
- Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance;
- Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;
- Establishing a policy for holding public hearings prior to approval of premium increases; and
- Establishing standards for Medicare SELECT policies and certificates.

The Commissioner may issue reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute, which, in the opinion of the Commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

D. Group and Blanket Health

2. Provisions — *section expanded as follows*:

Group accident and health insurance policies issued in Arkansas must contain the following required provisions:

- In the absence of fraud, all statements made by applicants, the policyowner, or insured person are deemed **representations** and not warranties;
- No statement can void coverage or reduce benefits, unless a written disclosure is signed by the policyholder, and a copy of the disclosure is provided to the policyholder, insured, and/or beneficiary;

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- Coverage cannot end for unmarried dependents of the insured who have reached the limiting age, but are incapable of self-sustainable employment due to a mental or physical disability and are dependent on the insured for support;
- Insurers must deliver a summary of essential policy features to each insured;
- Coverage may be extended to new eligible employees, members, or dependents;
- Group accident and health policies must provide outpatient coverage on the same basis and provide the same service as those under inpatient coverage, unless rejected in writing by the policyowner;
- Benefits must be payable immediately upon receipt of proof of loss and benefits for loss of time must be payable within **30 days** of the period for which the insurer is liable;
- Every insurer, hospital or medical service corporation, fraternal benefit society, self-funded healthcare plan, or HMO providing replacement coverage must provide immediate coverage to employees and dependents within **60 days** of discontinuance of a prior plan, as long as:
  - Each employee or dependent was covered under the previous plan;
  - Each employee or dependent is a member of the class of individuals eligible for coverage under the previous plan, regardless of plan limitations or exclusions relating to "actively at work" or hospital confinement; and
  - The previous plan provided coverage to at least **15 members**.

Continuation of Coverage — Every group accident and health insurance policy, other than accident only or specified disease policies, must contain a provision that any certificate holder, member or spouse whose coverage under a policy would end due to the termination of employment, group membership or change in marital status may continue coverage under the policy for themselves and any eligible dependent.

Continuation of coverage may only be made available to individuals who have been continuously insured for **3 months** prior to termination or change in marital status. An individual who wishes to continue coverage must request

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continuation in writing no later than **10 days** after the terminating event and pay the required premium on a monthly basis and in advance.

Coverage must end at the earliest of

- **120 days** after continuation of coverage began;
- The period for which the individual made a timely contribution;
- The insured becoming eligible for Medicare; or
- The date on which the policy is terminated, or the group withdraws from the plan, except for replacement.

Upon termination of continued coverage, an insurer must be offered a conversion policy.

Continued coverage does not need to include benefits for dental care, vision services, or prescription drug expenses. Coverage may not be continued for individuals eligible for Medicare or full coverage under another group health insurance policy.

Conversion of Coverage — Every group accident and health insurance policy issued in this state, other than coverage limited to expenses from accidents or specified diseases, must provide insureds under a terminated policy the option to **convert** their group policy **to an individual plan**. An individual must apply for conversion no later than **30 days** after termination of group coverage.

A converted policy must provide coverage equal to or greater than the minimum standards established by the Commissioner and contain the statement "*the benefits in this policy do not necessarily equal or match those benefits provided in your previous group policy.*" The initial premium for a conversion policy for the first year and subsequent renewal premiums are determined by individually underwritten standard risks for the age and class of risk and the type and amount of insurance provided.

Converted policies are prohibited from excluding coverage for pregnancy or other illness or injury on the grounds of a pre-existing condition which either exceeds or equals the waiting period of the original group plan.

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Individuals eligible for Medicare or other group health coverage are not eligible for conversion.

F. Health Maintenance Organizations — *section expanded as follows*:

The powers of a health maintenance organization (HMO) include, but are not limited to:

- Purchasing, leasing, or building hospitals or other health care facilities, including ancillary equipment;
- Making loans to health care providers or corporations for the purpose of constructing medical facilities and hospitals;
- Furnishing healthcare services through contracted providers;
- Contracting with people to perform marketing, enrollment, and administration duties;
- Offering additional healthcare services, indemnity benefits covering out-of-area emergency services, and indemnity benefits on a point-of-service basis; and
- Contracting with out-of-state providers who are licensed to provide medical care in the provider's jurisdiction.

HMOs must file a notice with the Commissioner when exercising powers. If the Commissioner does not disapprove the HMO's actions within **60 days** of filing, the exercise of power is approved.

HMOs that have been in operation for at least **2 years** may offer an annual open enrollment period of at least **1 month**.

In order to maintain financial stability, prevent adverse selection by prospective enrollees, and avoid unreasonably high charges, an HMO may impose underwriting restrictions, upon approval by the Commissioner. The Commissioner must approve or deny an application for underwriting restrictions within 60 days. HMOs providing services on a group contract basis may limit open enrollment to all members of the group.

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HMOs must provide to all enrollees **evidence of coverage** that must contain a statement of the following information:

- The health care services and the insurance or other benefits to which the enrollee is entitled under the contract;
- Any exclusions or limitations on the services, kinds of services, benefits or kinds of benefits to be provided, including any deductible or copayment feature and requirements for referrals prior to authorizations and second opinions;
- Where and how enrollees can get information about services;
- The total amount of payment and copayment, if any, for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and
- A description of the HMO's method for resolving enrollee complaints.

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