

Stricken language would be deleted from and underlined language would be added to present law.  
Act 860 of the Regular Session

State of Arkansas      *As Engrossed: H1/30/25 H3/17/25 S4/2/25*  
95th General Assembly      **A Bill**  
Regular Session, 2025

HOUSE BILL 1079

By: Representatives F. Allen, Wooten, K. Ferguson, J. Richardson

By: Senator D. Wallace

**For An Act To Be Entitled**

AN ACT TO MANDATE COVERAGE FOR GENETIC TESTING FOR AN  
INHERITED GENE MUTATION FOR CERTAIN INDIVIDUALS; TO  
MANDATE COVERAGE FOR EVIDENCE-BASED CANCER IMAGING  
FOR CERTAIN INDIVIDUALS; AND FOR OTHER PURPOSES.

**Subtitle**

TO MANDATE COVERAGE FOR GENETIC TESTING  
FOR AN INHERITED GENE MUTATION FOR  
CERTAIN INDIVIDUALS; AND TO MANDATE  
COVERAGE FOR EVIDENCE-BASED CANCER  
IMAGING FOR CERTAIN INDIVIDUALS.

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

SECTION 1. Arkansas Code Title 23, Chapter 79, is amended to add an  
additional subchapter to read as follows:

Subchapter 29 – Coverage for Genetic Testing for Inherited Gene Mutation and  
Evidence-based Cancer Imaging

23-79-2901. Definitions.

As used in this subchapter:

(1)(A) "Clinical utility" means a test result that provides  
information that is used in the formulation of a treatment or monitoring  
strategy that informs a patient's outcome and impacts the clinical decision.

(B) "Clinical utility" includes the most appropriate test  
that may include both information that is actionable and some information



that cannot be immediately used in the formulation of a clinical decision;

(2) "Evidence-based cancer imaging" means appropriate preventive screening and imaging supported by evidence;

(3) "Genetic testing for an inherited gene mutation" means testing for an inherited gene mutation associated with an increased risk of cancer;

(4)(A) "Health benefit plan" means an individual, blanket, or group plan, policy, or contract for healthcare services issued, renewed, or extended in this state by a healthcare insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state.

(B) "Health benefit plan" includes:

(i) Indemnity and managed care plans; and

(ii) Nonfederal governmental plans as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2025.

(C) "Health benefit plan" does not include:

(i) A plan that provides only dental benefits or eye and vision care benefits;

(ii) A disability income plan;

(iii) A credit insurance plan;

(iv) Insurance coverage issued as a supplement to liability insurance;

(v) Medical payments under an automobile or homeowners insurance plan;

(vi) A health benefit plan provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(vii) A plan that provides only indemnity for hospital confinement;

(viii) An accident-only plan;

(ix) A specified disease plan; or

(x) A long-term-care-only plan;

(5)(A) "Healthcare insurer" means any insurance company, hospital and medical service corporation, or health maintenance organization that issues or delivers health benefit plans in this state and is subject to any of the following laws:

(i) The insurance laws of this state;  
(ii) Section 23-75-101 et seq., pertaining to hospital and medical service corporations; or  
(iii) Section 23-76-101 et seq., pertaining to health maintenance organizations.

(B) "Healthcare insurer" does not include an entity that provides only dental benefits or eye and vision care benefits;

(6) "Healthcare provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer healthcare services; and

(7) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that:

(A) Are developed by independent organizations or medical professional societies:

(i) Using a transparent methodology and reporting structure; and

(ii) With a conflict of interest policy; and

(B) Establish standards of care that are informed by:

(i) A systemic review of evidence; and

(ii) An assessment of the benefits and costs of alternative care options that includes without limitation recommendations intended to optimize patient care.

23-79-2902. Coverage for genetic testing for inherited gene mutation and evidence-based cancer imaging.

(a) Beginning on and after January 1, 2026, a health benefit plan that is offered, issued, or renewed in this state shall provide coverage for:

(1) Genetic testing for an inherited gene mutation in a clinical setting for an individual with a personal or family history of cancer if the genetic testing for an inherited gene mutation:

(A) Provides clinical utility; and

(B) Is ordered or recommended by a healthcare provider and is supported by medical and scientific evidence, including without limitation:

(i) The National Comprehensive Cancer Network clinical practice recommendations that are level 2a or higher;

(ii) Centers for Medicare & Medicaid Services national coverage determinations or Medicare administrative contractor local coverage determinations; or

(iii) Nationally recognized clinical practice guidelines; and

(2) Evidence-based cancer imaging for an individual at an increased risk of developing cancer if the evidence-based cancer imaging:

(A) Provides clinical utility; and

(B) Is ordered or recommended by a healthcare provider according to:

(i) The National Comprehensive Cancer Network clinical practice recommendations that are level 2a or higher; or

(ii) Nationally recognized clinical practice guidelines.

(b)(1) Except as provided in subdivision (b)(2) of this section, the coverage for genetic testing for inherited gene mutation and evidence-based cancer imaging under subsection (a) of this section:

(A) Is not subject to an annual deductible, copayment, or coinsurance limit as established for other covered benefits under a health benefit plan; and

(B) Does not diminish or limit benefits otherwise allowable under a health benefit plan.

(2) This subsection does not apply to:

(A) A plan providing health benefits to state and public school employees under § 21-5-401 et seq.; or

(B) A self-funded governmental plan.

(c)(1) If application of this section would result in health savings account ineligibility under guidance issued by the United States Department of the Treasury under 26 U.S.C. § 223, as it existed on January 1, 2025, then this section shall apply only to health savings accounts with qualified high deductible health plans with respect to the deductible of a health benefit plan after the individual has satisfied the minimum deductible.

(2) This section does apply to items or services that are considered to be preventive care under 26 U.S.C. § 223(c)(2)(C), as it existed on January 1, 2025, whether or not the minimum deductible has been satisfied.

23-79-2903. Rules.

The Insurance Commissioner shall promulgate rules to implement and administer this subchapter.

*/s/F. Allen*

**APPROVED: 4/17/25**