Hall of the House of Representatives

88th General Assembly - Regular Session, 2011

Amendment Form

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Subtitle of House Bill No. 2138

TO REGULATE INSURANCE COMPANIES, INSURANCE PRACTICES, AND THE BUSINESS OF INSURANCE.

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Amendment No. 1 to House Bill No. 2138

Amend House Bill No. 2138 as originally introduced:

Delete Representative Hyde as a cosponsor of the bill

AND

Add Representatives Allen, Nickels as cosponsors of the bill

AND

Add Senator P. Malone as a sponsor

AND

Delete the title in its entirety and substitute the following:

"AN ACT TO ENSURE CONTINUED LOCAL REGULATION OF INDIVIDUAL HEALTH INSURANCE COVERAGE BY ENABLING THE INSURANCE COMMISSIONER TO CONTINUE SERVING ARKANSANS; TO IMPLEMENT FEDERAL HEALTHCARE REFORM; AND TO CREATE THE ARKANSAS HEALTH BENEFITS EXCHANGE; AND FOR OTHER PURPOSES."

AND

Delete the subtitle in its entirety and substitute the following:

"TO ALLOW THE INSURANCE COMMISSIONER TO PROTECT ARKANSANS BY THE CONTINUED LOCAL REGULATION OF INDIVIDUAL HEALTH INSURANCE COVERAGE."

AND

Delete everything after the enacting clause and substitute the following:

"SECTION 1. Arkansas Code § 23-61-103(a), concerning the authority of the Insurance Commissioner, is amended to read as follows:

(a) The Insurance Commissioner shall:

(1) ~~enforce the provisions of the Arkansas Insurance Code~~ Enforce the insurance laws of this state;

(2) Enforce and implement the provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, to the extent that the provisions apply to insurance companies and health maintenance organizations and other organizations created as a result of these federal laws subject to the commissioner's jurisdiction and to the extent that the provisions are not under the exclusive jurisdiction of any federal agency; and

(3) ~~shall execute~~ Execute the duties imposed upon him or her by the ~~Arkansas Insurance Code~~ insurance laws of this state.

SECTION 2. Arkansas Code § 23-79-109(h), concerning the filing and approval of insurance forms and rates is amended, and § 23-79-109 is amended to additional subsections, to read as follows:

(h)(1)(A) ~~If the commissioner deems that the review as to either rates or forms, or both, required by this section as to any particular line or lines of insurance, can be performed in some other manner that provides sufficient protection to the consumers of this state and results in greater efficiency in bringing new or modified products within the line to market, the approval required by this section may be waived for such period as is deemed appropriate, or until revoked.~~ Each insurance company, hospital and medical service corporation, and health maintenance organization shall file with the commissioner the schedules and tables of premium rates for individual accident and health insurance policies and shall file amendments to or corrections of the schedules and tables.

(B) Premium rates are subject to approval, disapproval, or withdrawal of approval by the commissioner.

(2) A rate filing by an entity for individual accident and health insurance premium rates is available for public inspection immediately on submission to the commissioner subject to § 23-61-103(d)(4).

(3) The commissioner shall specify the information all carriers shall submit as part of a rate filing under this section.

(4) The commissioner shall approve a proposed premium rate for individual accident and health policies if the proposed rates are:

(A) Actuarially sound; and

(B) Reasonable and not excessive, inadequate, or unfairly discriminatory.

(5) In order to determine if the proposed premium rates for individual accident and health policies are reasonable and not excessive, inadequate, or unfairly discriminatory, the commissioner shall consider:

(A) Historical and projected medical loss ratio;

(B) Changes to covered benefits;

(C) Changes in the insurer's health care cost containment and quality improvement efforts since the insurer's last rate filing for the same category of policies;

(D) Claim trend projections;

(E) Allocation of the overall rate increase to claims and nonclaims costs;

(F) Per enrollee per month allocation of current and projected premium;

(G) Three-year history of rate increases for the product associated with the rate increase;

(H) Employee and executive compensation data from the health insurance issuer's annual financial statements.

(I) An anticipated change in the number of policyholders, enrollees, or members if the proposed rate is approved; and

(J) Any public comments received pertaining to the standards in this section or the proposed rates for individual accident and health policies and individual HMO contracts.

(6)(A) If an insurer or HMO files a schedule or table of premium rates for individual accident and health coverage under insurance policies or a HMO contract under this section, the commissioner shall open a twenty (20) day public comment period on the rate filing that begins on the date the insurer or HMO files the schedule of table of premium rates.

(B) The commissioner shall post the comments to the website of the State Insurance Department.

(7)(A) Subsection (b) of this section shall apply to the rate filing.

(B) If the commissioner disapproves the filing, he or she shall notify the filer promptly.

(C) In the notice, the commissioner shall specify the reasons for his or her disapproval and the findings of fact and conclusion that support the reasons.

(i)(1) Each small employer carrier shall file each June 1 with the commissioner its schedule of rates or methodology for determining rates. No schedule of rates, or amendment thereto, may be used in conjunction with any small group accident and health insurance policy until either a copy of the schedule or the methodology for determining rates has been filed with and approved by the commissioner.

(2)(A) Either a specific schedule of rates or a methodology for determining rates shall be established in accordance with actuarial principles for various categories of enrollees, provided that rates applicable to an individual enrollee in a small group policy shall not be individually determined based on the status of the enrollee's health.

(B) However, the rates shall not be excessive, inadequate, or unfairly discriminatory.

(C) A certification by a qualified actuary, to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(3)(A) The commissioner, within a reasonable period, shall approve any schedule of rates or methodology for determining rates if the requirements of subdivision (i)(2) of this section are met.

(B) It shall be unlawful to use the schedule of rates or methodology for determining rates until approved.

(4)(A) If the commissioner disapproves the filing, he or she shall notify the filer promptly.

(B) In the notice, the commissioner shall specify the reasons for his or her disapproval and the findings of fact and conclusions that support the reasons.

(C) The commissioner shall grant a hearing within sixty (60) days after a request in writing by the person filing.

(D) If the commissioner does not disapprove any form or schedule of rates within sixty (60) days of the filing of the forms or schedule of rates, the form or schedule of rates shall be deemed approved.

(5) If the commissioner disapproves any schedule of rates or methodology for determining rates, his or her disapproval and the findings of fact and conclusions that support his or her reasons shall be subject to judicial review pursuant to § 23-61-307.

(6) The commissioner may require the submission of whatever relevant information he or she deems necessary to determine whether to approve or disapprove a filing made pursuant to this section.

(j) If the commissioner deems that the review of rates or forms or both rates and forms required by this section as to a particular line or lines of insurance can be performed in some other manner that provides sufficient protection to the consumers of this state and results in greater efficiency in bringing new or modified products within the line to market, the approval required by this section may be waived for a period as is deemed appropriate or until it is revoked.

SECTION 3. Arkansas Code § 23-79-110(5), concerning disapproval of rates for individual accident and health insurance policies, is repealed.

~~(5)(A) Is an individual accident and health contract in which the benefits are unreasonable in relation to the premium charge. Rates on a particular policy form will be deemed approved upon filing with the commissioner if the insurer has filed a loss ratio guarantee with the commissioner and complied with the terms of the loss ratio guarantee. Benefits will continue to be deemed reasonable in relation to the premium so long as the insurer complies with the terms of the loss ratio guarantee. This loss ratio guarantee must be in writing, signed by an officer of the insurer, and must contain at least the following:~~

~~(i) A recitation of the anticipated target loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved;~~

~~(ii) A guarantee that the actual Arkansas loss ratios for the experience period in which the new rates take effect, and for each experience period thereafter until new rates are filed, will meet or exceed the loss ratio standards referred to in subdivision (a)(5)(A)(i) of this section. If the annual earned premium volume in Arkansas under the particular policy form is less than one million dollars ($1,000,000) and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nationwide loss ratio for the policy form. If the aggregate earned premium for all states is less than one million dollars ($1,000,000), the experience period will be extended until the end of the calendar year in which one million dollars ($1,000,000) of earned premium is attained;~~

~~(iii) A guarantee that the actual Arkansas, or national, if applicable, loss ratio results for the year at issue will be independently audited at the insurer's expense. This audit must be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the commissioner not later than the date for filing the applicable accident and health policy experience exhibit;~~

~~(iv)(a) A guarantee that affected Arkansas policyholders will be issued a proportional refund, based on premium earned of the amount necessary to bring the actual aggregate loss ratio up to the loss ratio standards referred to in subdivision (a)(5)(A)(i) of this section. If nationwide loss ratios are used, then the total amount refunded in Arkansas will equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned in Arkansas on the policy form and divided by the total premium earned in all states on the policy form.~~

~~(b) The refund must be made to all Arkansas policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal ten dollars ($10.00) or more.~~

~~(c) The refund will include statutory interest from the end of the experience period until the date of payment.~~

~~(d) Payment must be made during the third quarter of the year following the experience period for which a refund is determined to be due; and~~

~~(v) A guarantee that refunds of less than ten dollars ($10.00) will be aggregated by the insurer and paid to the State Insurance Department.~~

~~(B) As used in this section, the term "loss ratio" means the ratio of incurred claims to earned premium by number of years of policy duration, for all combined durations.~~

~~(C) As used in this section, the term "experience period" means, for any given rate filing for which a loss ratio guarantee is made, the period beginning on the first day of the calendar year during which the rates first take effect and ending on the last day of the calendar year during which the insurer earns one million dollars ($1,000,000) in premium on the form in question in Arkansas or, if the annual premium earned on the form in Arkansas is less than one million dollars ($1,000,000) nationally. Successive experience periods shall be similarly determined beginning on the first day following the end of the preceding experience period.~~

~~(D)(i) An insurer whose rates on a policy form are approved pursuant to a loss ratio guarantee shall provide affected policyholders with a notice that advises that rates may be increased more than one (1) time a year. For new policyholders with policies subject to the loss ratio guarantee, the notice must be delivered no later than delivery of the policy.~~

~~(ii) Nothing in this section shall be deemed to require an insurer to provide the notice required by this subdivision on more than one (1) occasion to any given policyholder while insured under the guaranteed form.~~

SECTION 4. Arkansas Code § 23-86-115 is repealed.

~~23-86-115. Group accident and health insurance — Entitlement to conversion policy upon termination of group policy.~~

~~(a)(1) Every group policy, contract, or certificate of accident and health insurance delivered or issued for delivery in this state that provides hospital, surgical, or major medical coverage on an expense-incurred basis, other than coverage limited to expenses from accidents or specified diseases, shall provide that an employee, member, or covered dependent whose insurance~~

~~under the group policy has been terminated for any reason, including the discontinuance of the group policy in its entirety, shall be entitled to have issued to him or her by the insurer a policy of accident and health insurance referred to in this section as a "conversion policy".~~

~~(2) An employee, member, or dependent shall not be entitled to a conversion policy, if the termination of the group policy, contract, or certificate was a result of his or her failure to pay any required contribution or if the terminated policy is replaced by similar coverage within thirty-one (31) days.~~

~~(3) An individual wishing to exercise his or her conversion privilege must apply for the conversion policy in writing not later than thirty (30) days after the termination of the group coverage.~~

~~(b)(1)(A) The conversion policy shall provide coverage equal to or greater than the minimum standards established by the Insurance Commissioner.~~

~~(B) All conversion policies shall contain a wording in bold print that "the benefits in this policy do not necessarily equal or match those benefits provided in your previous group policy".~~

~~(2) The conversion policy shall not exclude coverage for pregnancy or other illness or injury on the grounds of a preexisting condition, provided that the combination of time served under the group and the conversion policy equals or exceeds any waiting periods under the group policy or contract. Moreover, the conversion policy shall include benefits for maternity coverage for any pregnancies in existence at the time of the conversion.~~

~~(c)(1) The insurer shall not be required to offer the conversion policy to any individual who is eligible for:~~

~~(A) Medicare coverage; or~~

~~(B) Full coverage under any other group accident and health policy or contract. This coverage must provide benefits for all preexisting conditions to be considered full coverage.~~

~~(2) Accordingly, under this subsection, an individual may convert to a conversion policy and remain covered by that policy until all preexisting conditions are covered or would be covered under another group policy or contract.~~

~~(d) This section shall not be applicable to self-insured plans.~~

~~(e)(1)(A) The initial premium for the conversion policy for the first twelve (12) months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks for the age and class of risk of each person to be covered under the conversion policy and for the type and amount of insurance provided.~~

~~(B) The experience under conversion policies shall not be an acceptable basis for establishing rates for conversion policies.~~

~~(2) For purposes of subdivision (e)(1) of this section:~~

~~(A) The phrase "premium rates applicable to individually underwritten standard risks" means the premium charged to individuals who qualify for coverage without modification, determined from a rate table based on aggregate individually underwritten policy experience;~~

~~(B) "Aggregate individually underwritten policy experience" means the policy experience is drawn from a mature combination of newly selected insureds and insureds for whom selection effects no longer exist; and~~

~~(C) "Class" means any actuarially determined characteristic, except health status or individual claims experience.~~

~~(3) If an insurer experiences incurred losses that exceed earned premiums for a period of two (2) successive years on conversion policies that have been in force for at least one (1) year, the insurer may file with the commissioner amended renewal rates for the subsequent year, which will produce a loss ratio of not less than one hundred percent (100%).~~

~~(4)(A) Even though a renewal premium is established in accordance with subdivision (e)(3) of this section, a holder of the conversion policy shall not be required to pay the full renewal premium until the beginning of the policy's fourth year.~~

~~(B) The premium for the second policy year shall be the initial premium plus thirty-three and one-third percent (33 1/3%) of the difference between the initial premium and the renewal premium in effect on the policy's first anniversary date.~~

~~(C) The premium for the third policy year shall be the initial premium plus sixty-six and two-thirds percent (66 2/3%) of the difference between the initial premium and the renewal premium in effect on the policy's second anniversary date.~~

~~(D) The premium for the fourth year shall be one hundred percent (100%) of the renewal premium in effect on the policy's third anniversary date.~~

~~(5) This subsection shall be applicable to any conversion policy issued after March 22, 1995.~~

SECTION 5. Arkansas Code § 23-86-303(34), concerning the definition of "small employer", is amended to read as follows:

(34) "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 two (2) but not more than ~~fifty (50)~~ <u>one hundred (100)</u> employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

SECTION 6. Arkansas Code Title 23, Chapter 98 is repealed.

~~23-98-101. Legislative findings.~~

~~The General Assembly finds that the cost of health insurance coverage is not affordable for many small businesses, their employees, self-employed persons, and other individuals, and that as a result hundreds of thousands of Arkansas citizens do not have any health insurance coverage. It is the intent of the General Assembly to reduce the cost of health insurance for these citizens by:~~

~~(1) Authorizing the development of new classes of hospital and medical insurance coverage for qualified groups, families, and individuals; and~~

~~(2) Authorizing the Insurance Commissioner to develop means to assist in limiting the marketing and administrative costs of certain of such new classes of insurance coverage.~~

~~23-98-102. Definitions.~~

~~As used in this chapter:~~

~~(1) "Children's preventive health care services" means physician-delivered or physician-supervised services for eligible dependents~~

~~from birth through age six (6), with periodic physical examinations including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations, and laboratory tests, in keeping with prevailing medical standards for the purposes of this section;~~

~~(2) "COBRA" means the "Consolidated Omnibus Budget Reconciliation Act of 1985";~~

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

~~(4) "Insured" means any individual or group insured under a minimum basic benefit policy issued pursuant to the provisions of this chapter;~~

~~(5) "Insurer" means an insurer, health maintenance organization, hospital, or medical service corporation offering a minimum basic benefit policy pursuant to this chapter;~~

~~(6) "Loss ratio" means the percentage derived by dividing incurred claims, both reported and not reported, by total premiums earned;~~

~~(7) "Minimum basic benefit policy" means a policy or subscription contract which an insurer may choose to offer to a qualified individual, qualified family, or qualified group pursuant to the provisions of this chapter;~~

~~(8) "Periodic physical examinations" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice;~~

~~(9) "Permitted coverages" means health or hospitalization coverage under a minimum basic benefit policy issued pursuant to this chapter, under Medicaid, Medicare, limited benefit policies as defined by rules and regulations of the commissioner, COBRA, or the provisions of § 23-86-114, § 23-86-115, or § 23-86-116;~~

~~(10) "Qualified family" means individuals all of whom are qualified individuals and all of whom are related by blood, marriage, or adoption;~~

~~(11) "Qualified group" means a group, organized other than pursuant to § 23-98-109, in which each covered individual, or covered dependent of such a covered individual, within the group is a qualified individual. A qualified group may include less than all employees of an employer;~~

~~(12)(A) "Qualified individual" means an individual who is employed in or is a resident of Arkansas and who has been without health insurance coverage, other than permitted coverage, for the twelve-month period immediately preceding the effective date of a minimum basic benefit policy issued pursuant to this chapter and who meets reasonable underwriting standards.~~

~~(B) However, children newborn to or adopted by an insured after the effective date of a policy issued to the insured pursuant to this chapter which covers the insured and members of the insured's family, shall be considered qualified individuals; and~~

~~(13) "Qualified trust" means a group organized pursuant to § 23-98-104 in which each covered individual, or covered dependent of such a covered individual, within the group is a qualified individual.~~

~~23-98-103. Notices and hearings before adopting regulations.~~

~~The Insurance Commissioner shall provide notice and conduct hearings in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et~~

~~seq., before adopting any regulations of general applicability to minimum basic benefit policies to be issued pursuant to this chapter.~~

~~23-98-104. Formation of trusts of qualified individuals.~~

~~Solely for purposes of obtaining minimum basic benefit policies pursuant to the authority granted by this chapter, trusts may be formed composed of qualified individuals, qualified families, or qualified groups. Each trust may serve as a master policyholder. Members of qualified groups and members of such trusts may join together solely for the purpose of obtaining health insurance coverage under the provisions of this chapter. The Insurance Commissioner shall adopt rules and regulations governing the formation and operation of the trust to assure the protection of persons purchasing policies pursuant to this chapter.~~

~~23-98-105. Issuance of minimum basic benefit policies permitted — Applicability.~~

~~Insurers are authorized to issue minimum basic benefit policies pursuant to and in compliance with the provisions of this chapter to qualified individuals, qualified families, qualified trusts, and qualified groups. This chapter shall apply only to those minimum basic benefit policies issued under this chapter and regulations issued by the Insurance Commissioner pursuant to the authority of this chapter. Nothing in this chapter shall be deemed to add to, detract from, or in any manner apply to policies, subscription contracts, benefits, or related activities under any other statutory or regulatory authorities.~~

~~23-98-106. Minimum basic benefits.~~

~~(a) Minimum basic benefit policies offered under the authority of this chapter shall provide basic levels of primary, preventive, and hospital care, including, but not limited to, the following:~~

~~(1) Fifteen (15) days of inpatient hospitalization coverage per policy year;~~

~~(2)(A) As an option, prenatal care, including:~~

~~(i) One (1) prenatal office visit per month during the first two (2) trimesters of pregnancy;~~

~~(ii) Two (2) office visits per month during the seventh and eighth months of pregnancy; and~~

~~(iii) One (1) office visit per week during the ninth month until term.~~

~~(B) Coverage for each office visit shall include:~~

~~(i) Necessary and appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member; and~~

~~(ii) Such prenatal counseling as the physician deems appropriate;~~

~~(3) As an option, obstetrical care, including physicians' services, delivery room, and other medically necessary hospital services;~~

~~(4)(A) As an option, coverage for children's preventive health care services on a periodic basis from birth through age six (6), including thirteen (13) visits at approximately the following age intervals:~~

~~(i) Birth;~~

~~(ii) Two (2) months;~~
~~(iii) Four (4) months;~~
~~(iv) Six (6) months;~~
~~(v) Nine (9) months;~~
~~(vi) Twelve (12) months;~~
~~(vii) Fifteen (15) months;~~
~~(viii) Eighteen (18) months;~~
~~(ix) Two (2) years;~~
~~(x) Three (3) years;~~
~~(xi) Four (4) years;~~
~~(xii) Five (5) years; and~~
~~(xiii) Six (6) years.~~

~~(B) The option may provide that children's preventive health care services which are rendered during a periodic review shall:~~

~~(i) Only be covered to the extent that these services are provided by or under the supervision of a single physician during the course of one (1) visit; and~~

~~(ii) Be reimbursed at levels established by the Insurance Commissioner which shall not exceed those established for the same services under the Medicaid program in the State of Arkansas.~~

~~(C) Copayment and deductible amounts shall not be greater than copayments and deductibles imposed for other physician's office visits;~~

~~(5) A basic level of primary and preventive care, including two (2) office visits per calendar year for covered services rendered by a provider licensed to provide the services rendered;~~

~~(6) Annual, lifetime, or other benefit limits in amounts not less than may be established by the commissioner but which initially shall be not less than one hundred thousand dollars ($100,000) as an annual benefit and two hundred fifty thousand dollars ($250,000) as a lifetime benefit;~~

~~(7) Such waiting period, if any, as the commissioner may establish for transferring from any minimum basic benefit policy issued under this chapter by one (1) insurer to a minimum basic benefit policy issued under this chapter by another insurer;~~

~~(8)(A) Every policy issued pursuant to this chapter which covers the insured and members of the insured's family shall include coverage for newborn infant children of the insured from the moment of birth, and for adopted minors from the date of the interlocutory decree of adoption.~~

~~(B) The insurer may require that the insured give notice to his or her insurer of any newborn children within ninety (90) days following the birth of the newborn infant and of any adopted child within sixty (60) days of the date the insured has filed a petition to adopt. The coverage of newborn children or adopted children shall not be less than the same as is provided for other members of the insured's family; and~~

~~(9) Such provisions, if any, as the commissioner may require, for:~~

~~(A) An annual or other deductible or equivalent;~~

~~(B) Patient copayments, including a differential, if any, for nonpreferred providers;~~

~~(C) Annual stop loss amounts;~~

~~(D) Continuation of coverage;~~

~~(E) Conversion;~~

~~(F) Replacement of prior carrier's coverage;~~

~~(G) Exclusionary periods for preexisting conditions; and~~

~~(H) Continuation of benefits.~~

~~(b) Notwithstanding the provisions of subsection (a) of this section, the commissioner shall consider the cost impact and essential nature of each of such requirements as well as the competitive impact of such requirements, and may vary any of such requirements, add, fix, or remove requirements or establish alternative benefit methods to encourage participation of insurers in a manner consistent with meeting the goal of providing minimum basic health services at an affordable price to those eligible for coverage under this chapter.~~

~~(c) The commissioner may authorize a waiver of any of the policy provisions required pursuant to this section or the commissioner's authority under this section in order to authorize a minimum basic benefit policy to be issued as a medicaid supplement without requiring redundant coverage.~~

~~(d)(1) Any minimum basic benefit policy issued pursuant to the provisions of this chapter may be issued without the provision of the benefitsor requirements mandated by the following statutes to be included in or offered to be included in accident and health insurance or health maintenance organization policies or subscription contracts or regulations issued pursuant to such statutes: §§ 23-79-129, 23-79-130, 23-79-137, 23-79-139 — 23-79-141, 23-85-131(b), 23-85-137, 23-86-108(4) and (7), 23-86-113 — 23-86-116, and 23-86-118.~~

~~(2) However, nothing in this chapter shall:~~

~~(A) Reduce any professional scope of practice as defined in the licensure law for any health care provider;~~

~~(B) Authorize any discrimination not permitted under Arkansas law in payment or reimbursement for services; or~~

~~(C) Be construed to repeal or eliminate the application of the Arkansas freedom of choice legislation, § 23-79-114, or coordination of benefit statutes or regulations to policies issued pursuant to this chapter.~~

~~23-98-107. Disclosure requirements for minimum basic benefit policies. Statute text~~

~~(a) Before any insurer issues a minimum basic benefit policy, it shall obtain from the prospective insured a signed, written statement, in a form approved by the Insurance Commissioner, in which the prospective insured:~~

~~(1) Certifies as to eligibility for coverage under the minimum basic benefit policy;~~

~~(2) Acknowledges the limited nature of the coverage provided and an understanding of the managed care and cost control features of the minimum basic benefit policy;~~

~~(3) Acknowledges that if misrepresentations are made regarding the insured's eligibility for coverage under a minimum basic benefit policy, then the person making the misrepresentations shall forfeit coverage provided by the minimum basic benefit policy; and~~

~~(4) Acknowledges that the prospective insured, at the time of application for the minimum basic benefit policy, was offered the opportunity to purchase health insurance coverage which would have included all mandated or mandated optional benefits required by Arkansas law and that the prospective insured rejected such coverage.~~

~~(b) A copy of the written statement shall be provided to the prospective insured no later than at the time of minimum basic benefit policy~~

~~delivery, and the original of the written statement shall be retained by the insurer for the longer of either the period of time in which the minimum basic benefit policy remains in effect or five (5) years.~~

~~(c) At the time coverage under a minimum basic benefit policy shall take effect for an insured, the insurer shall provide the insured with a written disclosure statement containing such information as the commissioner shall require and in a form approved by the commissioner. The disclosure statement shall be separate from the insurance policy or evidence of coverage provided to the insured. The disclosure statement shall contain at least the following information:~~

~~(1) An explanation of those mandated or mandated optional benefits not covered by the minimum basic benefit policy but which would otherwise be required to be provided under Arkansas law;~~

~~(2) An explanation of the managed care and cost control features of the minimum basic benefit policy, along with all appropriate mailing addresses and telephone numbers to be utilized by the insured in seeking information or authorization, as well as a list of any preferred providers then contracting with the insurer, and an explanation of the obligations of the providers and the insured with regard to services determined not to be medically necessary; and~~

~~(3) An explanation of the primary and preventive care features of the minimum basic benefit policy.~~

~~(d) Any material statement made by an applicant for coverage under a minimum basic benefit policy which falsely certifies as to the applicant's eligibility for coverage under a minimum basic benefit policy shall serve as the basis for termination of coverage under any minimum basic benefit policy issued to the applicant.~~

~~23-98-108. Notice of minimum basic benefit policies — Payroll deduction.~~

~~(a) Those employers in the State of Arkansas that do not provide a portion of the cost of health insurance for their employees shall provide notice to their employees of the existence of the minimum basic benefit policy authorized by this chapter. The notice shall be in a form prepared by the Insurance Commissioner and may be provided to employees by posting at the place of employment or in any other reasonable manner.~~

~~(b) Any insured, or dependent of an insured, under this chapter may provide written request to his or her employer to withhold the amount of premium on a minimum basic benefit policy from his or her paycheck along with written instructions for remittance of the premium, in which case the employer shall withhold the premium and remit the premium payment to the insurer, unless to do so would require the employer to make remittances to more than three (3) different insurers.~~

~~(c) No employer required to make a remittance of a premium under the provisions of this chapter shall be required to make such remittances more often than one (1) time per month.~~

~~(d) Nothing in this chapter shall be construed to require or mandate in any way that an employer provide or pay any portion of the cost of a minimum basic benefit policy issued under this chapter.~~

~~(e) Upon request by the commissioner, the Arkansas Employment Security Department is authorized to provide a copy of the form of notice prepared by~~

~~the commissioner to employers as the commissioner and the department may agree upon.~~

~~23-98-109. Managed care and cost control provisions.~~

~~(a) The insurer may include any or all of the following managed care provisions to control the cost of a minimum basic benefit policy issued pursuant to this chapter:~~

~~(1) An exclusion for services that are not medically necessary;~~

~~(2) A procedure for preauthorization by telephone, to be confirmed in writing, by the insurer or its designee of any medical service, the cost of which is anticipated to exceed a minimum threshold, except for services necessary to treat a medical emergency;~~

~~(3)(A) A preferred panel of providers who have entered into written agreements with the insurer to provide services at specified levels of reimbursement.~~

~~(B) With the exception of health maintenance organizations, participation in such a preferred panel shall be open to all providers licensed to provide the services to be covered.~~

~~(C)(i) Any such written agreement between a provider and an insurer shall contain a provision under which the parties agree that the insured individual or covered member will have no obligation to make payment for any medical service rendered by the provider that is determined not to be medically necessary.~~

~~(ii) However, charges for medically necessary services received by the insured which are not covered by the minimum basic benefit policy shall be considered the responsibility of the insured; and~~

~~(4)(A) A provision under which any insured who obtains medical services from a nonpreferred provider shall receive reimbursement only in the amount that would have been received had services been rendered by a preferred provider, less a differential, if any, in an amount to be approved by the Insurance Commissioner but which may not exceed twenty-five percent (25%).~~

~~(B) However, charges for medically necessary services received by the insured which are not covered by the minimum basic benefit policy shall be considered the responsibility of the insured.~~

~~(b) Nothing in this chapter shall be construed to prohibit an insurer from including in a minimum basic benefit policy other managed care and cost control provisions which, subject to the approval of the commissioner, have the potential to control costs in a manner which does not result in inequitable treatment of an insured under this chapter.~~

~~23-98-110. Approval of forms and rates.~~

~~(a) All minimum basic benefit policy forms, including applications, enrollment forms, policies, certificates, evidences of coverage, riders, amendments, endorsements, disclosure forms, and marketing communications used in connection with the sale or advertisement of a minimum basic benefit policy shall be submitted to the Insurance Commissioner for approval in the same manner as required by § 23-79-109(a) or § 23-76-112(a).~~

~~(b) Minimum basic benefit policies are subject to the filing and approval statutes, rules, and regulations of the state. No rate shall be considered reasonable nor shall it be approved unless:~~

~~(1) It is based upon a pool, community rating, or other rating formula acceptable to the commissioner; and~~

~~(2)(A) As to individual policies and policies issued to qualified trusts, it is likely to produce a loss ratio, as certified by a qualified actuary, which is acceptable to the commissioner, but in no event shall such a loss ratio be less than sixty-five percent (65%).~~

~~(B) However, the commissioner may set a minimum loss ratio for group policies issued pursuant to this chapter if the commissioner determines that inequitable or unfair treatment of policyholders would otherwise result.~~

~~(c) To the extent that an insurer has a surplus in a given year which has been generated on minimum basic benefit policies issued pursuant to this chapter to a qualified group by a loss ratio of less than seventy-five percent (75%) or issued pursuant to this chapter to qualified individuals, qualified families, or qualified trusts by a loss ratio of less than sixty-five percent (65%), that surplus shall be taken into consideration in setting rates in following years in such manner as to benefit the holders of such minimum basic benefit policies.~~

~~(d)(1) The commissioner may require that as to each minimum basic benefit policy approved, the insurer provide a statement of the portion of the rate or premium applicable to the minimum basic benefit policy coverage required by this chapter, or the commissioner pursuant to this chapter, or such other information as the commissioner may require so that prospective purchasers of policies pursuant to this chapter may have an ability to make a direct comparison of the cost of the minimum basic benefits within policies of the same class issued by different insurers.~~

~~(2) The commissioner may include rate comparison or other cost information in the form of notice which may be provided by the commissioner to employers pursuant to this chapter.~~

~~23-98-111. Record-keeping and reporting requirement for insurers.~~

~~Each insurer issuing a minimum basic benefit policy in this state shall maintain separate and distinct records of enrollment, claim costs, premium income, utilization, and such other information as may be required by the Insurance Commissioner. Each insurer providing a minimum basic benefit policy shall furnish an annual report to the commissioner in a form prescribed by the commissioner which shall contain such information as the commissioner may require to analyze the effect of insurance coverage issued pursuant to this chapter. The annual report required shall be in a form consistent with the forms, if any, adopted by the National Association of Insurance Commissioners for such a purpose.~~

SECTION 7. Arkansas Code Title 23 is amended to add an additional chapter to read as follows:

Chapter 104 — Arkansas Health Benefits Exchange Act

23-104-101. Title.

This chapter shall be known and may be cited as the "Arkansas Health Benefits Exchange Act".

23-104-102. Purpose and intent.

The purpose of this chapter is to provide for the establishment of a second insurance marketplace called the "Arkansas Health Benefits Exchange"

to supplement the current insurance marketplace and to facilitate the purchase and sale of qualified health plans in the individual market in the State of Arkansas and to provide for the establishment of a Small Business Health Options Program to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans offered through the exchange in the small group market.

23-104-103. Definitions.

As used in this chapter:

(1) "Educated health care consumer" means an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters;

(2)(A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse the costs of health care services.

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

(i) Coverage for accident-only or disability income insurance or any combination of accident-only or disability income insurance;

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

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

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage specified in federal regulations issued under the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, under which the benefits for health care services are secondary or incidental to other insurance benefits.

(C) If the benefits are provided under a separate policy, certificate, or contract of insurance or otherwise are not an integral part of the plan, "health benefit plan" does not include:

(i) Limited dental or vision benefits;

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

(iii) Other similar limited benefits specified in federal regulations issued under the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191.

(D) If the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the benefits and an exclusion of benefits under a group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under a group health plan maintained by the same plan sponsor, "health benefit plan" does not include:

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

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) If offered as a separate policy, certificate, or contract of insurance, "health benefit plan" does not include:

(i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act, as it existed on January 1, 2011;

(ii) Supplemental coverage provided under 10 U.S.C. Chapter 55, the Civilian Health and Medical Program of the Uniformed Services; or

(iii) Similar supplemental coverage provided under a group health plan;

(3) "Health carrier" means an entity subject to the insurance laws of this state or the jurisdiction of the Insurance Commissioner that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse the costs of health care services, including:

(A) An accident and health insurance company;

(B) A health maintenance organization;

(C) A nonprofit hospital and medical service corporation; or

(D) Any other entity providing a plan of health insurance, health benefits, or health services;

(4) "Principal place of business" means the location in a state where an employer has its headquarters or significant place of business and where the persons with direction and control authority over the business are employed;

(5) "Qualified dental plan" means a limited-scope dental plan that has been certified in accordance with § 23-104-107;

(6) "Qualified employer" means a small employer that elects to make its full-time employees and some or all of its part-time employees eligible for one (1) or more qualified health plans offered through the Small Business Health Options Program if the employer:

(A) Has its principal place of business in this state and elects to provide coverage through the Small Business Health Options Program to all of its eligible employees, wherever employed; or

(B) Elects to provide coverage through the Small Business Health Options Program to its eligible employees who are principally employed in this state;

(7) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and § 23-104-107;

(8) "Qualified individual" means an individual, including a minor, who:

(A) Is seeking to enroll in a qualified health benefit plan offered through the Arkansas Health Benefits Exchange;

(B) Resides in this state;

(C) At the time of enrollment is not incarcerated other than incarceration pending the disposition of charges; and

(D) Is a citizen or national of the United States or an alien lawfully present in the United States; and

(9)(A) "Small employer" means an employer that employed an average of at least two (2) but not more than fifty (50) employees during the

preceding calendar year and who employs at least two (2) employees on the first day of the plan year unless the commissioner determines that the purposes or administration of this chapter is better served by an increase in the maximum average number of employees during the preceding calendar year not to exceed one hundred (100).

(B) For purposes of this subdivision (9):

(i) A person treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, as it existed on January 1, 2011, shall be treated as a single employer;

(ii) An employer and any predecessor employer shall be treated as a single employer; and

(iii) Each employee shall be counted, including part-time employees and employees who are not eligible for coverage through the employer.

(C) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected the employer will employ on business days in the current calendar year.

(D) An employer that makes enrollment in qualified health plans available to its employees through the Small Business Health Options Program and would cease to be a small employer by reason of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the Small Business Health Options Program available to its employees.

23-104-104. Establishment of Arkansas Health Benefits Exchange.

(a) There is created a nonprofit legal entity to be known as the "Arkansas Health Benefits Exchange" the purpose of which will be to increase the access to quality and affordable health care coverage, reduce the number of uninsured persons in Arkansas, and increase availability and consumer choice of health care coverage through the exchange to qualified individuals and small employers.

(b) All health carriers licensed to sell accident and health insurance or health maintenance organization contracts may participate in the exchange.

(c)(1)(A) The exchange shall operate subject to the supervision and control of the Board of Directors of the Arkansas Health Benefits Exchange.

(B) The exchange is created as a political subdivision, instrumentality, and body politic of the State of Arkansas, and as such, is not a state agency.

(2) Except to the extent provided in this chapter, the exchange shall be exempt from:

(A) All state, county, and local taxes;

(B) The Arkansas Procurement Law, § 19-11-201 et seq.;

(C) The Arkansas Public Officers and Employees Law, § 21-1-101 et seq.; and

(D) The Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(3)(A) The board shall consist of seven (7) voting members appointed by the Insurance Commissioner.

(B) At least three (3) of the seven (7) voting board members shall have experience in health care benefits administration, health care economics, or health insurance or health-insurance-related actuarial principles.

(C) One (1) of the voting board members shall represent the interests of health-benefit-plan consumers in this state.

(D) One (1) of the voting board members shall represent the interests of small employers in this state.

(E) One (1) of the voting board members shall be a representative of a hospital located in Arkansas.

(F) One (1) of the voting board members shall be a health care provider licensed to practice in Arkansas.

(4) The commissioner or his or her representative, the Director of the Department of Human Services or his or her representative, the Director of the Office of Health Information Technology or his or her representative, the Director of the Department of Health, and the Director of the Arkansas Center for Health Improvement or his or her representative shall be nonvoting ex officio members of the board.

(5)(A) The voting members of the board shall serve staggered three-year terms.

(B) The initial term of two (2) of the voting members shall be one (1) year, the initial term of two (2) of the voting members shall be two (2) years, and the initial term of the remaining three (3) voting members shall be three (3) years to allow for continuity.

(C) The voting members shall draw lots to determine the lengths of their initial terms.

(D) Voting members may be reappointed for additional terms.

(6) The chair of the board shall be elected annually from the voting members of the board by the voting members of the board.

(7) Any vacancy among the voting members of the board occurring for any reason other than the expiration of a term shall be filled for the unexpired term in the same manner as the original appointment.

(8) Voting members of the board may be reimbursed from moneys of the exchange for actual and necessary expenses incurred by them in the performance of their official duties as members of the board but shall not otherwise be compensated for their services.

(d) The board may provide in its bylaws or rules for indemnification of, and legal representation for, the board members and employees.

(e) The exchange shall:

(1) Facilitate the purchase and sale of qualified health plans;

(2) Provide for the establishment of a Small Business Health Options Program to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans; and

(3) Meet the requirements of this chapter and any rules implemented under this chapter.

(f)(1)(A) The exchange may contract with an eligible entity for the functions described in this chapter.

(B) An eligible entity includes without limitation the State Insurance Department or an entity that has experience in individual and small group health insurance.

(2) A health carrier or its affiliate is not an eligible entity.

(g) The exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this chapter, provided that the agreements include adequate protection with respect to the confidentiality of the information to be shared and comply with state and federal laws.

23-104-105. General requirements.

(a) The Arkansas Health Benefits Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning on or before January 1, 2014.

(b)(1) The exchange shall not make available a health benefit plan that is not a qualified health plan.

(2) The exchange shall allow a health carrier to offer a plan through the exchange that provides limited-scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986, as it existed on January 1, 2011, separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

(c) The exchange or a health carrier offering qualified health benefit plans through the exchange shall not charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986, as it existed on January 1, 2011.

23-104-106. Duties of Arkansas Health Benefits Exchange.

The Arkansas Health Benefits Exchange shall:

(1) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary of the United States Department of Health and Human Services under section 1311(c) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and § 23-104-107 of health benefit plans as qualified health plans;

(2) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(3) Provide for enrollment periods, under section 1311(c)(6) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

(4) Maintain a website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on plans;

(5) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary of the United States Department of Health and Human Services under section 1311(c)(3) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and determine each qualified health plan's level

of coverage in accordance with regulations issued by the Secretary of the United States Department of Health and Human Services under section 1302(d)(2)(A) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

(6) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act, 42 U.S.C. § 201 et seq. as it existed on January 1, 2011;

(7)(A) In accordance with section 1413 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program under title XXI of the Social Security Act, or any applicable state or local public program.

(B) If through screening of the application by the exchange the exchange determines that an individual is eligible for a program, enroll that individual in that program;

(8) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of a premium tax credit under section 36B of the Internal Revenue Code of 1986, as it existed on January 1, 2011, and any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

(9) Establish a Small Business Health Options Program through which qualified employers may access coverage for their employees that shall enable a qualified employer to specify a level of coverage among those offered on the exchange so its employees may enroll in a qualified health plan offered through the Small Business Health Options Program at the specified level of coverage;

(10) Subject to section 1411 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, as it existed on January 1, 2011, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(A) There is not an affordable qualified health plan available through the exchange or through the individual's employer to cover the individual; or

(B) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty;

(11) Transfer to the Secretary of the United States Department of the Treasury the following:

(A) A list of the individuals who are issued a certification under subdivision (10) of this section, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986, as it existed on January 1, 2011, because:

(i) The employer did not provide minimum essential coverage; or

(ii) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986, as it existed on January 1, 2011, to be unaffordable to the employee or not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

(i) Each individual who notifies the exchange under section 1411(b)(4) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, that he or she has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(12) Provide to each employer the name of each employee of the employer described in subdivision (11)(B) of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(13) Perform duties required of the exchange by the Secretary of the United States Department of Health and Human Services or the Secretary of the United States Department of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

(14)(A) Select entities qualified to serve as "Navigators" in accordance with section 1311(i) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and award grants to enable Navigators to:

(i) Conduct public education activities to raise awareness of the availability of qualified health plans;

(ii) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986, as it existed on January 1, 2011, and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

(iii) Facilitate enrollment in qualified health plans;

(iv) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, 42 U.S.C. § 201 et seq., as it existed on January 1, 2011, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan, coverage, or a determination under that health benefit plan or coverage;

(v) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(vi) Counsel exchange participants about selecting or transitioning among Medicaid, the federal Children's Health Insurance Programs, and other coverage; and

(vii) Insure significant numbers of Navigators to serve disadvantaged, hard-to-reach populations.

(B) The state may require individuals affiliated with any Navigator contract to be certified, licensed, or otherwise deemed able to carry out the duties as required by section 1131(i)(3) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

(15) Review the rate of premium growth within the exchange and of non-grandfathered health benefit plans outside the exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(16) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and collect the amount credited from the offering employer;

(17) Consult with stakeholders relevant to carrying out the activities required under this chapter, including:

(A) Educated health care consumers who are enrollees in qualified health plans;

(B) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) The commissioner;

(D) Representatives of health carriers that offer qualified health plans through the exchange;

(E) Representatives of health carriers that are not offering qualified health plans through the exchange;

(F) Representatives of small businesses and self-employed individuals;

(G) The Department of Human Services, the Department of Health, the Office of Health Information Technology, the Department of Information Systems, and the Arkansas Center for Health Improvement; and

(H) Advocates for enrolling disadvantaged, hard-to-reach populations;

(18) Meet the following financial integrity requirements:

(A) Keep an accurate account of all activities, receipts, and expenditures and annually submit to Secretary of the United States Department of Health and Human Services, the Governor, the commissioner, and the General Assembly a report concerning such accountings;

(B) Fully cooperate with any investigation conducted by the Secretary of the United States Department of Health and Human Services pursuant to his or her authority under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and allow the Secretary of the United States Department of Health and Human Services, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(C) In carrying out its activities under this chapter, not use any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications; and

(19) Appoint at least one (1) or more advisory committee as deemed appropriate by the Board of Directors of the Arkansas Health Benefits Exchange.

23-104-107. Health benefit plan certification.

(a) The Arkansas Health Benefits Exchange shall certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package described in section 1302(a) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection (d) of this section, if:

(A) The exchange has determined that an adequate choice of qualified dental plans is available to supplement the plan's coverage; and

(B) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange;

(2) The premium rates and contract language have been approved by the Insurance Commissioner;

(3) The plan provides at least a "bronze" level of coverage, as determined pursuant to subsection 1311(c)(3) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and if the plan is offered through the Small Business Health Options Program and the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

(5) The health carrier offering the plan:

(A) Is licensed and in good standing to offer accident and health insurance or health maintenance organization coverage in this state;

(B) Offers at least one (1) qualified health plan in the "silver" level, as defined in subsection 1302(d)(1)(B) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152,

and at least one (1) plan in the "gold" level, as defined in subsection 1302(d)(1)(C) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, through each "component" of the exchange in which the carrier participates, where component refers to the Small Business Health Options Program and the exchange for individual coverage;

(C) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange or through the non-exchange open market and without regard to whether the plan is offered directly from the health carrier or through an insurance producer;

(D) Does not charge any cancellation fees or penalties in violation of § 23-104-105(c); and

(E) Complies with the regulations developed by the Secretary of the United States Department of Health and Human Services under section 1311(d) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and such other requirements as the exchange may establish;

(6) The plan meets the requirements of certification as promulgated by regulation by the Secretary of the United States Department of Health and Human Services under section 1311(c)(1) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and by the exchange; and

(7) The exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

(b) The exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the exchange; or

(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

(c) Presumption of Best Interest.

(1) In order to foster a competitive exchange marketplace and consumer choice, it is presumed to be in the interest of qualified individuals and qualified employers for the exchange to certify all health plans meeting the requirements of section 1311(c) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, for participation in the exchange.

(2)(A) The exchange shall certify all health plans meeting the requirements of section 1311(c) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and § 23-104-107 for participation in the exchange.

(B) The exchange shall establish and publish a transparent, objective process for decertifying qualified health plans to be offered through the exchange that are determined not to be in the public interest.

(d) The exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1)(A) Submit a justification for any premium increase before implementation of that increase.

(B) The health carrier shall prominently post the information on its Internet website.

(C) The exchange shall take this information, along with the information and the recommendations provided to the exchange by the commissioner under section 2794(b) of the Public Health Service Act, 42 U.S.C. § 201 et seq., as it existed on January 1, 2011, into consideration when determining whether to allow the health carrier to make plans available through the exchange;

(2)(A) Make available to the public, in the format described in subdivision (A)(2)(B) of this section, and submit to the exchange, the Secretary of the United States Department of Health and Human Services, and the commissioner accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

(v) Data on the number of claims that are denied;

(vi) Data on rating practices;

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) Information on enrollee and participant rights under title I of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and

(ix) Other information as determined appropriate by the Secretary of the United States Department of Health and Human Services.

(B) The information required in subdivision (d)(2)(A) of this section shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and

(3)(A) Permit individuals to learn in a timely manner upon the request of the individual the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider.

(B) At a minimum, this information shall be made available to the individual through a website and through other means for individuals without access to the Internet.

(e)(1) The provisions of this chapter that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with subdivisions (e)(2)-(4) of this section or by rules adopted by the commissioner.

(2) The health carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and shall include at a minimum

the essential pediatric dental benefits prescribed by the Secretary of the United States Department of Health and Human Services pursuant to section 1302(b)(1)(J) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and such other minimum dental benefits as the exchange or the Secretary of the United States Department of Health and Human Services may specify by regulation.

(4) A health carrier and a dental carrier may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by the dental carrier and the other benefits are provided by the health carrier.

(f) Appeal of Decertification or Denial of Certification.

(1) The exchange shall give each health carrier the opportunity to appeal a decertification decision or the denial of certification as a qualified health plan.

(2) The exchange shall give each health carrier that appeals a decertification decision or the denial of certification the opportunity for:

(A) The submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue; and

(B) A hearing and a decision on the record, to the extent that the exchange and the health carrier are unable to reach agreement following the submission of the information in subdivision (f)(2)(A) of this section.

(3) Any hearing held pursuant to subdivision (f)(2)(B) of this section shall be conducted by an impartial party or an administrative law judge with appropriate legal training and in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

23-104-108. Choice.

(a) In accordance with section 1312(f)(2)(A) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, a qualified employer may either designate one (1) or more qualified health plans from which its employees may choose or designate any level of coverage to be made available to employees through the Arkansas Health Benefits exchange.

(b) In accordance with section 1312(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health carrier issuing the qualified health plan.

(c) Risk Pooling.

In accordance with section 1312(c) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152:

(1) A health carrier shall consider all enrollees in all health plans, other than grandfathered health plans, offered by the health carrier in the individual market, including enrollees who do not enroll in such plans through the exchange, members of a single risk pool.

(2) A health carrier shall consider all enrollees in all health plans, other than grandfathered health plans, offered by the health carrier in the small group market, including those enrollees who do not enroll in

such plans through the Small Business Health Options Program, to be members of a single risk pool.

(d) Empowering Consumer Choice.

(1) In accordance with section 1312(d) of the Federal Act:

(A) This chapter shall not prohibit:

(i) A health carrier from offering outside of the exchange a health plan to a qualified individual or qualified employer; or

(ii) A qualified individual from enrolling in or a qualified employer from selecting for its employees a health plan offered outside of the exchange; and

(B) This chapter shall not limit the operation of any requirement under state law or rule with respect to any policy or plan that is offered outside of the exchange with respect to any requirement to offer benefits.

(2) Voluntary Nature of the Exchange.

(A) Nothing in this chapter shall restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in the exchange.

(B) Nothing in this chapter shall compel an individual to enroll in a qualified health plan or to participate in the exchange.

(C) A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

(e) Enrollment through Agents or Brokers.

In accordance with section 1312(e) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, the exchange may allow agents or brokers:

(1) To enroll qualified individuals and qualified employers in any qualified health plan offered through the exchange for which the individual or employer is eligible; and

(2) To assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health plans purchased through the exchange.

23-104-109. Funding -- Taxes, fees, and assessments -- Medical loss ratio -- Publication of costs.

(a)(1)(A) As required by section 1311(d)(5)(A) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, the Arkansas Health Benefits Exchange shall be self-sustaining by January 1, 2015.

(B) A budget for the exchange shall be prepared by the exchange and submitted to the Insurance Commissioner annually for approval.

(2) The exchange may charge assessments or user fees to health carriers up to three percent (3%) of each health carrier's direct written

premium from health benefit plans sold through the exchange or otherwise may receive funding necessary to support its operations provided under this chapter.

(3) Any assessments or fees charged to carriers are limited to the minimum amount necessary to pay for the administrative costs and expenses that have been approved in the annual budget process, after consideration of other available funding.

(4) Services performed by the exchange on behalf of other state or federal programs shall not be funded with assessments or user fees collected from health carriers.

(5) Any unspent funding by an exchange shall be used for future state operation of the exchange or returned to health carriers as a credit.

(b) Taxes, fees, or assessments used to finance the exchange shall be clearly disclosed by the exchange as such, including publishing the average cost of licensing, regulatory fees, and any other payments required by the exchange, and the administrative costs of the exchange on a website to educate consumers on such costs.

(c) Taxes, fees, or assessments used to finance the exchange shall be considered a state tax or assessment as defined under section 2718(a) in the Public Health Service Act, 42 U.S.C. § 201 et seq., as it existed on January 1, 2011, and its implementing regulations, and shall be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates.

(d)(1) The exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange and the administrative costs of the exchange on an Internet website to educate consumers on such costs.

(2) This information shall include information on moneys lost to waste, fraud, and abuse.

23-104-110. Rules.

(a) The Insurance Commissioner may promulgate rules to implement this chapter.

(b) Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary of the United States Department of Health and Human Services under title I, subtitle D of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

23-104-111. Relation to other laws.

(a) Nothing in this chapter, and no action taken by the Arkansas Health Benefits Exchange pursuant to this chapter, shall be construed to preempt or supersede the authority of the Insurance Commissioner to regulate the business of insurance within this state.

(b) Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and rules adopted and orders issued by the commissioner.

23-104-112. Plan of operation.

(a)(1)(A) The Arkansas Health Benefits Exchange shall submit to the Insurance Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and required administration of the exchange.

(B) The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or, unless he or she has not disapproved the plan of operation, within thirty (30) days.

(2) If the exchange fails to submit a suitable plan of operation within one hundred eighty (180) days following June 1, 2011, or if at any time thereafter the exchange fails to submit suitable amendments to the plan of operation, the commissioner, after notice and public hearing, shall adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter.

(3) The rules shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the exchange and approved by the commissioner.

(b) The plan of operation in addition to requirements enumerated elsewhere in this chapter, shall:

(1) Establish procedures for handling the assets of the exchange;

(2) Establish the amount and method of reimbursing members of the Board of Directors of the Arkansas Health Benefits Exchange;

(3) Establish regular places and times for meeting, including telephone conference calls of the board;

(4) Establish procedures for all record keeping required in this chapter;

(5) Establish a conflict of interest policy for the board; and

(6) Contain additional provisions necessary or proper for the execution of powers and duties of the exchange."

The Amendment was read _____

By: Representative Hyde

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ANS153 **Chief Clerk**