

1 State of Arkansas  
2 88th General Assembly  
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4

As Engrossed: H3/21/11 H3/24/11

# A Bill

HOUSE BILL 2138

5 By: Representatives *Allen, Nickels*  
6 By: Senator *P. Malone*  
7

## For An Act To Be Entitled

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

## Subtitle

15  
16  
17  
18 *TO ALLOW THE INSURANCE COMMISSIONER TO*  
19 *PROTECT ARKANSANS BY THE CONTINUED LOCAL*  
20 *REGULATION OF INDIVIDUAL HEALTH INSURANCE*  
21 *COVERAGE.*  
22  
23

24 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:  
25

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

28 *(a) The Insurance Commissioner shall:*

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

31 *(2) Enforce and implement the provisions of the Patient*  
32 *Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the*  
33 *Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, to*  
34 *the extent that the provisions apply to insurance companies and health*  
35 *maintenance organizations and other organizations created as a result of*  
36 *these federal laws subject to the commissioner's jurisdiction and to the*



1 extent that the provisions are not under the exclusive jurisdiction of any  
2 federal agency; and

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

5  
6 SECTION 2. Arkansas Code § 23-79-109(h), concerning the filing and  
7 approval of insurance forms and rates is amended, and § 23-79-109 is amended  
8 to additional subsections, to read as follows:

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

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

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

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

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

29 (A) Actuarially sound; and

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

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

35 (A) Historical and projected medical loss ratio;

36 (B) Changes to covered benefits;

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

4 (D) Claim trend projections;

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

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

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

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

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

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

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

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

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

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

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

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

1 approved by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

35 (j) If the commissioner deems that the review of rates or forms or  
36 both rates and forms required by this section as to a particular line or

1 lines of insurance can be performed in some other manner that provides  
2 sufficient protection to the consumers of this state and results in greater  
3 efficiency in bringing new or modified products within the line to market,  
4 the approval required by this section may be waived for a period as is deemed  
5 appropriate or until it is revoked.

6  
7 SECTION 3. Arkansas Code § 23-79-110(5), concerning disapproval of  
8 rates for individual accident and health insurance policies, is repealed.

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

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

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

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

1 ~~date for filing the applicable accident and health policy experience exhibit;~~  
2 ~~(iv)(a) A guarantee that affected Arkansas~~  
3 ~~policyholders will be issued a proportional refund, based on premium earned~~  
4 ~~of the amount necessary to bring the actual aggregate loss ratio up to the~~  
5 ~~loss ratio standards referred to in subdivision (a)(5)(A)(i) of this section.~~  
6 ~~If nationwide loss ratios are used, then the total amount refunded in~~  
7 ~~Arkansas will equal the dollar amount necessary to achieve the loss ratio~~  
8 ~~standards multiplied by the total premium earned in Arkansas on the policy~~  
9 ~~form and divided by the total premium earned in all states on the policy~~  
10 ~~form.~~

11 ~~(b) The refund must be made to all Arkansas~~  
12 ~~policyholders who are insured under the applicable policy form as of the last~~  
13 ~~day of the experience period and whose refund would equal ten dollars~~  
14 ~~(\$10.00) or more.~~

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

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

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

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

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

35 ~~(D)(i) An insurer whose rates on a policy form are~~  
36 ~~approved pursuant to a loss ratio guarantee shall provide affected~~

1 ~~policyholders with a notice that advises that rates may be increased more~~  
2 ~~than one (1) time a year. For new policyholders with policies subject to the~~  
3 ~~loss ratio guarantee, the notice must be delivered no later than delivery of~~  
4 ~~the policy.~~

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

9  
10 SECTION 4. Arkansas Code § 23-86-115 is repealed.

11 ~~23-86-115. Group accident and health insurance — Entitlement to~~  
12 ~~conversion policy upon termination of group policy.~~

13 ~~(a)(1) Every group policy, contract, or certificate of accident and~~  
14 ~~health insurance delivered or issued for delivery in this state that provides~~  
15 ~~hospital, surgical, or major medical coverage on an expense-incurred basis,~~  
16 ~~other than coverage limited to expenses from accidents or specified diseases,~~  
17 ~~shall provide that an employee, member, or covered dependent whose insurance~~  
18 ~~under the group policy has been terminated for any reason, including the~~  
19 ~~discontinuance of the group policy in its entirety, shall be entitled to have~~  
20 ~~issued to him or her by the insurer a policy of accident and health insurance~~  
21 ~~referred to in this section as a “conversion policy”.~~

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

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

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

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

35 ~~(2) The conversion policy shall not exclude coverage for~~  
36 ~~pregnancy or other illness or injury on the grounds of a preexisting~~

1 ~~condition, provided that the combination of time served under the group and~~  
2 ~~the conversion policy equals or exceeds any waiting periods under the group~~  
3 ~~policy or contract. Moreover, the conversion policy shall include benefits~~  
4 ~~for maternity coverage for any pregnancies in existence at the time of the~~  
5 ~~conversion.~~

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

8 ~~(A) Medicare coverage; or~~

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

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

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

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

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

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

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

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

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

36 ~~(3) If an insurer experiences incurred losses that exceed earned~~

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

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

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

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

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

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

22  
23 SECTION 5. Arkansas Code § 23-86-303(34), concerning the definition of  
24 "small employer", is amended to read as follows:

25 (34) "Small employer" means, in connection with a group health plan  
26 with respect to a calendar year and a plan year, an employer who employed an  
27 average of at least two (2) but not more than ~~fifty (50)~~ one hundred (100)  
28 employees on business days during the preceding calendar year and who employs  
29 at least two (2) employees on the first day of the plan year;

30  
31 SECTION 6. Arkansas Code Title 23, Chapter 98 is repealed.

32 ~~23-98-101. Legislative findings.~~

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

1 ~~of the General Assembly to reduce the cost of health insurance for these~~  
2 ~~citizens by:~~

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

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

9  
10 ~~23-98-102. Definitions.~~

11 ~~As used in this chapter:~~

12 ~~(1) "Children's preventive health care services" means~~  
13 ~~physician-delivered or physician-supervised services for eligible dependents~~  
14 ~~from birth through age six (6), with periodic physical examinations including~~  
15 ~~medical history, physical examination, developmental assessment, anticipatory~~  
16 ~~guidance and appropriate immunizations, and laboratory tests, in keeping with~~  
17 ~~prevailing medical standards for the purposes of this section;~~

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

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

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

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

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

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

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

36 ~~(9) "Permitted coverages" means health or hospitalization~~

1 ~~coverage under a minimum basic benefit policy issued pursuant to this~~  
2 ~~chapter, under Medicaid, Medicare, limited benefit policies as defined by~~  
3 ~~rules and regulations of the commissioner, COBRA, or the provisions of § 23-~~  
4 ~~86-114, § 23-86-115, or § 23-86-116;~~

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

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

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

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

23 ~~(13) "Qualified trust" means a group organized pursuant to § 23-~~  
24 ~~98-104 in which each covered individual, or covered dependent of such a~~  
25 ~~covered individual, within the group is a qualified individual.~~

26  
27 ~~23-98-103. Notices and hearings before adopting regulations.~~

28 ~~The Insurance Commissioner shall provide notice and conduct hearings in~~  
29 ~~accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et~~  
30 ~~seq., before adopting any regulations of general applicability to minimum~~  
31 ~~basic benefit policies to be issued pursuant to this chapter.~~

32  
33 ~~23-98-104. Formation of trusts of qualified individuals.~~

34 ~~Solely for purposes of obtaining minimum basic benefit policies~~  
35 ~~pursuant to the authority granted by this chapter, trusts may be formed~~  
36 ~~composed of qualified individuals, qualified families, or qualified groups.~~

1 ~~Each trust may serve as a master policyholder. Members of qualified groups~~  
2 ~~and members of such trusts may join together solely for the purpose of~~  
3 ~~obtaining health insurance coverage under the provisions of this chapter. The~~  
4 ~~Insurance Commissioner shall adopt rules and regulations governing the~~  
5 ~~formation and operation of the trust to assure the protection of persons~~  
6 ~~purchasing policies pursuant to this chapter.~~

7  
8 ~~23-98-105. Issuance of minimum basic benefit policies permitted—~~  
9 ~~Applicability.~~

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

19  
20 ~~23-98-106. Minimum basic benefits.~~

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

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

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

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

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

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

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

34 ~~(i) Necessary and appropriate screening, including~~  
35 ~~history, physical examination, and such laboratory and diagnostic procedures~~  
36 ~~as may be deemed appropriate by the physician based upon recognized medical~~

1 ~~criteria for the risk group of which the patient is a member; and~~

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

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

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

9 ~~(i) Birth;~~

10 ~~(ii) Two (2) months;~~

11 ~~(iii) Four (4) months;~~

12 ~~(iv) Six (6) months;~~

13 ~~(v) Nine (9) months;~~

14 ~~(vi) Twelve (12) months;~~

15 ~~(vii) Fifteen (15) months;~~

16 ~~(viii) Eighteen (18) months;~~

17 ~~(ix) Two (2) years;~~

18 ~~(x) Three (3) years;~~

19 ~~(xi) Four (4) years;~~

20 ~~(xii) Five (5) years; and~~

21 ~~(xiii) Six (6) years.~~

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

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

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

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

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

35 ~~(6) Annual, lifetime, or other benefit limits in amounts not~~  
36 ~~less than may be established by the commissioner but which initially shall be~~

1 ~~not less than one hundred thousand dollars (\$100,000) as an annual benefit~~  
2 ~~and two hundred fifty thousand dollars (\$250,000) as a lifetime benefit;~~

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

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

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

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

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

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

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

23 ~~(D) Continuation of coverage;~~

24 ~~(E) Conversion;~~

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

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

27 ~~(H) Continuation of benefits.~~

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

36 ~~(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 benefits or 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~~

1 ~~to purchase health insurance coverage which would have included all mandated~~  
2 ~~or mandated optional benefits required by Arkansas law and that the~~  
3 ~~prospective insured rejected such coverage.~~

4 ~~(b) A copy of the written statement shall be provided to the~~  
5 ~~prospective insured no later than at the time of minimum basic benefit policy~~  
6 ~~delivery, and the original of the written statement shall be retained by the~~  
7 ~~insurer for the longer of either the period of time in which the minimum~~  
8 ~~basic benefit policy remains in effect or five (5) years.~~

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

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

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

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

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

33  
34 ~~23-98-108. Notice of minimum basic benefit policies — Payroll~~  
35 ~~deduction.~~

36 ~~(a) Those employers in the State of Arkansas that do not provide a~~

1 ~~portion of the cost of health insurance for their employees shall provide~~  
2 ~~notice to their employees of the existence of the minimum basic benefit~~  
3 ~~policy authorized by this chapter. The notice shall be in a form prepared by~~  
4 ~~the Insurance Commissioner and may be provided to employees by posting at the~~  
5 ~~place of employment or in any other reasonable manner.~~

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

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

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

19 ~~(e) Upon request by the commissioner, the Arkansas Employment Security~~  
20 ~~Department is authorized to provide a copy of the form of notice prepared by~~  
21 ~~the commissioner to employers as the commissioner and the department may~~  
22 ~~agree upon.~~

23  
24 ~~23-98-109. Managed care and cost control provisions.~~

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

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

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

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

36 ~~(B) With the exception of health maintenance~~

1 ~~organizations, participation in such a preferred panel shall be open to all~~  
2 ~~providers licensed to provide the services to be covered.~~

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

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

11 ~~(4)(A) A provision under which any insured who obtains medical~~  
12 ~~services from a nonpreferred provider shall receive reimbursement only in the~~  
13 ~~amount that would have been received had services been rendered by a~~  
14 ~~preferred provider, less a differential, if any, in an amount to be approved~~  
15 ~~by the Insurance Commissioner but which may not exceed twenty-five percent~~  
16 ~~(25%).~~

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

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

25  
26 ~~23-98-110. Approval of forms and rates.~~

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

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

36 ~~(1) It is based upon a pool, community rating, or other rating~~

1 ~~formula acceptable to the commissioner; and~~

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

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

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

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

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

29  
30 ~~23-98-111. Record keeping and reporting requirement for insurers.~~

31 ~~Each insurer issuing a minimum basic benefit policy in this state shall~~  
32 ~~maintain separate and distinct records of enrollment, claim costs, premium~~  
33 ~~income, utilization, and such other information as may be required by the~~  
34 ~~Insurance Commissioner. Each insurer providing a minimum basic benefit policy~~  
35 ~~shall furnish an annual report to the commissioner in a form prescribed by~~  
36 ~~the commissioner which shall contain such information as the commissioner may~~

~~1 require to analyze the effect of insurance coverage issued pursuant to this  
2 chapter. The annual report required shall be in a form consistent with the  
3 forms, if any, adopted by the National Association of Insurance Commissioners  
4 for such a purpose.~~

5  
6 SECTION 7. Arkansas Code Title 23 is amended to add an additional  
7 chapter to read as follows:

8 Chapter 104 – Arkansas Health Benefits Exchange Act

9 23-104-101. Title.

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

12  
13 23-104-102. Purpose.

14 The purpose of this chapter is to provide for the establishment of a  
15 second insurance marketplace called the "Arkansas Health Benefits Exchange"  
16 to supplement the current insurance marketplace and to facilitate the  
17 purchase and sale of qualified health plans in the individual market in the  
18 State of Arkansas and to provide for the establishment of a Small Business  
19 Health Options Program to assist qualified small employers in this state in  
20 facilitating the enrollment of their employees in qualified health plans  
21 offered through the exchange in the small group market.

22  
23 23-104-103. Definitions.

24 As used in this chapter:

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

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

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

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

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

1 (iii) Liability insurance, including general  
2 liability and automobile liability insurance;  
3 (iv) Workers' compensation or similar insurance;  
4 (v) Automobile medical payment insurance;  
5 (vi) Credit-only insurance;  
6 (vii) Coverage for on-site medical clinics; or  
7 (viii) Other similar insurance coverage specified in  
8 federal regulations issued under the Health Insurance Portability and  
9 Accountability Act, Pub. L. No. 104-191, under which the benefits for health  
10 care services are secondary or incidental to other insurance benefits.

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

14 (i) Limited dental or vision benefits;  
15 (ii) Benefits for long-term care, nursing-home care,  
16 home-health care, community-based care, or any combination thereof; or  
17 (iii) Other similar limited benefits specified in  
18 federal regulations issued under the Health Insurance Portability and  
19 Accountability Act, Pub. L. No. 104-191.

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

27 (i) Coverage for only a specified disease or  
28 illness; or  
29 (ii) Hospital indemnity or other fixed indemnity  
30 insurance.

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

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

36 (ii) Supplemental coverage provided under 10 U.S.C.

1 Chapter 55, the Civilian Health and Medical Program of the Uniformed  
2 Services; or

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

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

9 (A) An accident and health insurance company;

10 (B) A health maintenance organization;

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

12 or

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

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

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

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

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

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

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

36 (8) "Qualified individual" means an individual, including a

1 minor, who:

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

4 (B) Resides in this state;

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

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

9 (9)(A) "Small employer" means an employer that employed an  
10 average of at least two (2) but not more than fifty (50) employees during the  
11 preceding calendar year and who employs at least two (2) employees on the  
12 first day of the plan year unless the commissioner determines that the  
13 purposes or administration of this chapter is better served by an increase in  
14 the maximum average number of employees during the preceding calendar year  
15 not to exceed one hundred (100).

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

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

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

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

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

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

1  
2 23-104-104. Establishment of Arkansas Health Benefits Exchange.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36 (F) One (1) of the voting board members shall be a health

1 care provider licensed to practice in Arkansas.

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

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

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

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

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

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

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

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

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

29 (e) The exchange shall:

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

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

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

36 (f)(1)(A) The exchange may contract with an eligible entity for the

1 functions described in this chapter.

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

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

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

11  
12 23-104-105. General requirements.

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

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

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

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

33  
34 23-104-106. Duties of Arkansas Health Benefits Exchange.

35 The Arkansas Health Benefits Exchange shall:

36 (1) Implement procedures for the certification, recertification, and

1 decertification, consistent with guidelines developed by the Secretary of the  
2 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  
4 amended by the Health Care and Education Reconciliation Act of 2010, Pub. L.  
5 No. 111-152, and § 23-104-107 of health benefit plans as qualified health  
6 plans;

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

9 (3) Provide for enrollment periods, under section 1311(c)(6) of the  
10 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended  
11 by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-  
12 152;

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

16 (5) Assign a rating to each qualified health plan offered through the  
17 exchange in accordance with the criteria developed by the Secretary of the  
18 United States Department of Health and Human Services under section  
19 1311(c)(3) of the Patient Protection and Affordable Care Act, Pub. L. No.  
20 111-148, as amended by the Health Care and Education Reconciliation Act of  
21 2010, Pub. L. No. 111-152, and determine each qualified health plan's level  
22 of coverage in accordance with regulations issued by the Secretary of the  
23 United States Department of Health and Human Services under section  
24 1302(d)(2)(A) of the Patient Protection and Affordable Care Act, Pub. L. No.  
25 111-148, as amended by the Health Care and Education Reconciliation Act of  
26 2010, Pub. L. No. 111-152;

27 (6) Use a standardized format for presenting health benefit options in  
28 the exchange, including the use of the uniform outline of coverage  
29 established under section 2715 of the Public Health Service Act, 42 U.S.C. §  
30 201 et seq. as it existed on January 1, 2011;

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

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

4 (8) Establish and make available by electronic means a calculator to  
5 determine the actual cost of coverage after application of a premium tax  
6 credit under section 36B of the Internal Revenue Code of 1986, as it existed  
7 on January 1, 2011, and any cost-sharing reduction under section 1402 of the  
8 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended  
9 by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-  
10 152;

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

17 (10) Subject to section 1411 of the Patient Protection and Affordable  
18 Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education  
19 Reconciliation Act of 2010, Pub. L. No. 111-152, grant a certification  
20 attesting that, for purposes of the individual responsibility penalty under  
21 section 5000A of the Internal Revenue Code of 1986, as it existed on January  
22 1, 2011, an individual is exempt from the individual responsibility  
23 requirement or from the penalty imposed by that section because:

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

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

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

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

34 (B) The name and taxpayer identification number of each  
35 individual who was an employee of an employer but who was determined to be  
36 eligible for the premium tax credit under section 36B of the Internal Revenue

1 Code of 1986, as it existed on January 1, 2011, because:

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

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

8 (C) The name and taxpayer identification number of:

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

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

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

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

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

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

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

1 152;

2 (iii) Facilitate enrollment in qualified health plans;

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

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

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

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

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

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

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

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

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

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

3 (C) The commissioner;

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

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

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

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

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

15 (18) Meet the following financial integrity requirements:

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

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

28 (i) Investigate the affairs of the exchange;

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

30 and

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

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

1 modifications; and

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

5  
6 23-104-107. Health benefit plan certification.

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

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

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

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

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

24 (3) The plan provides at least a "bronze" level of coverage, as  
25 determined pursuant to subsection 1311(c)(3) of the Patient Protection and  
26 Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and  
27 Education Reconciliation Act of 2010, Pub. L. No. 111-152, unless the plan is  
28 certified as a qualified catastrophic plan, meets the requirements of the  
29 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended  
30 by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-  
31 152 for catastrophic plans, and will only be offered to individuals eligible  
32 for catastrophic coverage;

33 (4) The plan's cost-sharing requirements do not exceed the  
34 limits established under section 1302(c)(1) of the Patient Protection and  
35 Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and  
36 Education Reconciliation Act of 2010, Pub. L. No. 111-152, and if the plan is

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

6 (5) The health carrier offering the plan:

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

9 (B) Offers at least one (1) qualified health plan in the  
10 "silver" level, as defined in subsection 1302(d)(1)(B) of the Patient  
11 Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the  
12 Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152,  
13 and at least one (1) plan in the "gold" level, as defined in subsection  
14 1302(d)(1)(C) of the Patient Protection and Affordable Care Act, Pub. L. No.  
15 111-148, as amended by the Health Care and Education Reconciliation Act of  
16 2010, Pub. L. No. 111-152, through each "component" of the exchange in which  
17 the carrier participates, where component refers to the Small Business Health  
18 Options Program and the exchange for individual coverage;

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

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

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

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

1 exchange; and

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

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

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

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

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

12 (c) Presumption of Best Interest.

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

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

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

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

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

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

35 (C) The exchange shall take this information, along with  
36 the information and the recommendations provided to the exchange by the

1 commissioner under section 2794(b) of the Public Health Service Act, 42  
2 U.S.C. § 201 et seq., as it existed on January 1, 2011, into consideration  
3 when determining whether to allow the health carrier to make plans available  
4 through the exchange;

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

9 (i) Claims payment policies and practices;

10 (ii) Periodic financial disclosures;

11 (iii) Data on enrollment;

12 (iv) Data on disenrollment;

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

14 (vi) Data on rating practices;

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

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

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

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

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

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

36 (e)(1) The provisions of this chapter that are applicable to qualified

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

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

6 (3) The plan shall be limited to dental and oral health  
7 benefits, without substantially duplicating the benefits typically offered by  
8 health benefit plans without dental coverage, and shall include at a minimum  
9 the essential pediatric dental benefits prescribed by the Secretary of the  
10 United States Department of Health and Human Services pursuant to section  
11 1302(b)(1)(J) of the Patient Protection and Affordable Care Act, Pub. L. No.  
12 111-148, as amended by the Health Care and Education Reconciliation Act of  
13 2010, Pub. L. No. 111-152, and such other minimum dental benefits as the  
14 exchange or the Secretary of the United States Department of Health and Human  
15 Services may specify by regulation.

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

20 (f) Appeal of Decertification or Denial of Certification.

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

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

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

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

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

36

1 23-104-108. Choice.

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

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

14 (c) Risk Pooling.

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

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

22 (2) A health carrier shall consider all enrollees in all health  
23 plans, other than grandfathered health plans, offered by the health carrier  
24 in the small group market, including those enrollees who do not enroll in  
25 such plans through the Small Business Health Options Program, to be members  
26 of a single risk pool.

27 (d) Empowering Consumer Choice.

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

29 (A) This chapter shall not prohibit:

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

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

35 (B) This chapter shall not limit the operation of any  
36 requirement under state law or rule with respect to any policy or plan that

1 is offered outside of the exchange with respect to any requirement to offer  
2 benefits.

3 (2) Voluntary Nature of the Exchange.

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

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

9 (C) A qualified individual may enroll in any qualified  
10 health plan, except that in the case of a catastrophic plan described in  
11 section 1302(e) of the Patient Protection and Affordable Care Act, Pub. L.  
12 No. 111-148, as amended by the Health Care and Education Reconciliation Act  
13 of 2010, Pub. L. No. 111-152, a qualified individual may enroll in the plan  
14 only if the individual is eligible to enroll in the plan under section  
15 1302(e)(2) of the Patient Protection and Affordable Care Act, Pub. L. No.  
16 111-148, as amended by the Health Care and Education Reconciliation Act of  
17 2010, Pub. L. No. 111-152.

18 (e) Enrollment through Agents or Brokers.

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

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

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

29  
30 23-104-109. Funding -- Taxes, fees, and assessments -- Medical loss  
31 ratio -- Publication of costs.

32 (a)(1)(A) As required by section 1311(d)(5)(A) of the Patient  
33 Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the  
34 Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152,  
35 the Arkansas Health Benefits Exchange shall be self-sustaining by January 1,  
36 2015.

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

3 (2) The exchange may charge assessments or user fees to health  
4 carriers up to three percent (3%) of each health carrier's direct written  
5 premium from health benefit plans sold through the exchange or otherwise may  
6 receive funding necessary to support its operations provided under this  
7 chapter.

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

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

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

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

22 (c) Taxes, fees, or assessments used to finance the exchange shall be  
23 considered a state tax or assessment as defined under section 2718(a) in the  
24 Public Health Service Act, 42 U.S.C. § 201 et seq., as it existed on January  
25 1, 2011, and its implementing regulations, and shall be excluded from health  
26 plan administrative costs for the purpose of calculating medical loss ratios  
27 or rebates.

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

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

34  
35 23-104-110. Rules.

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

1 chapter.

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

8  
9 23-104-111. Relation to other laws.

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

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

18  
19 23-104-112. Plan of operation.

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

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

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

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

36 (b) The plan of operation in addition to requirements enumerated

1 elsewhere in this chapter, shall:

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

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

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

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

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

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

13  
14 SECTION 8. LEGISLATIVE CONSTRUCTION AND INTENT.

15 (a) The General Assembly declares that:

16 (1) This act is not to be construed as either resisting or  
17 supporting the Patient Protection and Affordable Care Act, Pub. L. No. 111-  
18 148, as amended by the Health Care and Education Reconciliation Act of 2010,  
19 Pub. L. No. 111-152; and

20 (2) The sole intent of this act is to maintain the current  
21 localized regulation of health insurance in the State of Arkansas.

22 (b) If any provision of the Patient Protection and Affordable Care  
23 Act, Pub. L. No. 111-148, as amended by the Health Care and Education  
24 Reconciliation Act of 2010, Pub. L. No. 111-152, is held to be  
25 unconstitutional in a final, nonappealable order or is repealed by the United  
26 States Congress, any part of this act affected by the unconstitutional or  
27 repealed provision shall be null and void.

28  
29 /s/Allen  
30  
31  
32  
33  
34  
35  
36