

Stricken language would be deleted from and underlined language would be added to present law.

1 State of Arkansas  
2 88th General Assembly  
3 Regular Session, 2011  
4

As Engrossed: H3/21/11 H3/24/11 H3/29/11

# 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~~

1 ~~provisions required pursuant to this section or the commissioner's authority~~  
 2 ~~under this section in order to authorize a minimum basic benefit policy to be~~  
 3 ~~issued as a medicaid supplement without requiring redundant coverage.~~

4 ~~(d)(1) Any minimum basic benefit policy issued pursuant to the~~  
 5 ~~provisions of this chapter may be issued without the provision of the~~  
 6 ~~benefits or requirements mandated by the following statutes to be included in~~  
 7 ~~or offered to be included in accident and health insurance or health~~  
 8 ~~maintenance organization policies or subscription contracts or regulations~~  
 9 ~~issued pursuant to such statutes: §§ 23-79-129, 23-79-130, 23-79-137, 23-79-~~  
 10 ~~139, 23-79-141, 23-85-131(b), 23-85-137, 23-86-108(4) and (7), 23-86-113-~~  
 11 ~~23-86-116, and 23-86-118.~~

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

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

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

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

20  
 21 ~~23-98-107. Disclosure requirements for minimum basic benefit policies.~~  
 22 ~~Statute text~~

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

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

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

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

35 ~~(4) Acknowledges that the prospective insured, at the time of~~  
 36 ~~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

1 insurance;

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

4 (iv) Workers' compensation or similar insurance;

5 (v) Automobile medical payment insurance;

6 (vi) Credit-only insurance;

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

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

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

15 (i) Limited dental or vision benefits;

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

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

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

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

30 (ii) Hospital indemnity or other fixed indemnity  
31 insurance.

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

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

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

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

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

10 (A) An accident and health insurance company;

11 (B) A health maintenance organization;

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

13 or

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

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

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

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

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

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

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

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

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

5                   (B) Resides in this state;

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

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

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

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

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

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

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

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

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

1 through the Small Business Health Options Program available to its employees.

2  
3 23-104-104. Establishment of Arkansas Health Benefits Exchange.

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

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

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

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

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

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

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

21 (C) The Arkansas Public Officers and Employees Law, § 21-  
22 1-101 et seq.; and

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

30 (e) The exchange shall:

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

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

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

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

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

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

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

12  
13 23-104-105. General requirements.

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

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

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

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

34  
35 23-104-106. Duties of Arkansas Health Benefits Exchange.

36 The Arkansas Health Benefits Exchange shall:

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

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

10 (3) Provide for enrollment periods, under section 1311(c)(6) of the  
11 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended  
12 by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-  
13 152;

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

17 (5) Assign a rating to each qualified health plan offered through the  
18 exchange in accordance with the criteria developed by the Secretary of the  
19 United States Department of Health and Human Services under section  
20 1311(c)(3) of the Patient Protection and Affordable Care Act, Pub. L. No.  
21 111-148, as amended by the Health Care and Education Reconciliation Act of  
22 2010, Pub. L. No. 111-152, and determine each qualified health plan's level  
23 of coverage in accordance with regulations issued by the Secretary of the  
24 United States Department of Health and Human Services under section  
25 1302(d)(2)(A) of the Patient Protection and Affordable Care Act, Pub. L. No.  
26 111-148, as amended by the Health Care and Education Reconciliation Act of  
27 2010, Pub. L. No. 111-152;

28 (6) Use a standardized format for presenting health benefit options in  
29 the exchange, including the use of the uniform outline of coverage  
30 established under section 2715 of the Public Health Service Act, 42 U.S.C. §  
31 201 et seq. as it existed on January 1, 2011;

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

1 of the Social Security Act, or any applicable state or local public program.

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

5 (8) Establish and make available by electronic means a calculator to  
6 determine the actual cost of coverage after application of a premium tax  
7 credit under section 36B of the Internal Revenue Code of 1986, as it existed  
8 on January 1, 2011, and any cost-sharing reduction under section 1402 of the  
9 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended  
10 by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-  
11 152;

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

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

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

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

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

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

35 (B) The name and taxpayer identification number of each  
36 individual who was an employee of an employer but who was determined to be

1 eligible for the premium tax credit under section 36B of the Internal Revenue  
2 Code of 1986, as it existed on January 1, 2011, because:

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

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

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

10 (i) Each individual who notifies the exchange under  
11 section 1411(b)(4) 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, that he or she has changed employers; and

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

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

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

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

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

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

1 by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-  
2 152;

3 (iii) Facilitate enrollment in qualified health plans;

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

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

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

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

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

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

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

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

36 (A) Educated health care consumers who are enrollees in

1 qualified health plans;

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

4 (C) The commissioner;

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

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

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

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

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

16 (18) Meet the following financial integrity requirements:

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

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

29 (i) Investigate the affairs of the exchange;

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

31 and

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

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

1 compensation, or promotion of federal or state legislative and regulatory  
2 modifications; and

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

6  
7 23-104-107. Health benefit plan certification.

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

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

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

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

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

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

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



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

7 (5) The health carrier offering the plan:

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

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

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

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

27 (E) Complies with the regulations developed by the  
28 Secretary of the United States Department of Health and Human Services under  
29 section 1311(d) 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 such other requirements as the exchange may  
32 establish;

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

1 and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and by the  
2 exchange; and

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

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

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

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

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

13 (c) Presumption of Best Interest.

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

21 (2)(A) The exchange shall certify all health plans meeting the  
22 requirements of section 1311(c) 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, and § 23-104-107 for  
25 participation in the exchange.

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

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

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

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

36 (C) The exchange shall take this information, along with

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

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

10 (i) Claims payment policies and practices;

11 (ii) Periodic financial disclosures;

12 (iii) Data on enrollment;

13 (iv) Data on disenrollment;

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

15 (vi) Data on rating practices;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1  
2 23-104-108. Choice.

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

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

15 (c) Risk Pooling.

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

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

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

28 (d) Empowering Consumer Choice.

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

30 (A) This chapter shall not prohibit:

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

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

36 (B) This chapter shall not limit the operation of any

1 requirement under state law or rule with respect to any policy or plan that  
2 is offered outside of the exchange with respect to any requirement to offer  
3 benefits.

4 (2) Voluntary Nature of the Exchange.

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

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

10 (C) A qualified individual may enroll in any qualified  
11 health plan, except that in the case of a catastrophic plan described in  
12 section 1302(e) of the Patient Protection and Affordable Care Act, Pub. L.  
13 No. 111-148, as amended by the Health Care and Education Reconciliation Act  
14 of 2010, Pub. L. No. 111-152, a qualified individual may enroll in the plan  
15 only if the individual is eligible to enroll in the plan under section  
16 1302(e)(2) of the Patient Protection and Affordable Care Act, Pub. L. No.  
17 111-148, as amended by the Health Care and Education Reconciliation Act of  
18 2010, Pub. L. No. 111-152.

19 (e) Enrollment through Agents or Brokers.

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

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

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

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

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

1 2015.

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

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

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

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

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

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

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

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

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

35  
36 23-104-110. Rules.

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

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

9  
10 23-104-111. Relation to other laws.

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

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

19  
20 23-104-112. Plan of operation.

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

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

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

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



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

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

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

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

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

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

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

14  
15 SECTION 8. LEGISLATIVE CONSTRUCTION AND INTENT.

16 (a) The General Assembly declares that:

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

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

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

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30 SECTION 9. EFFECTIVE DATE.

31 (a) Section 23-61-103(a)(2) and Section 7 of this Act shall not take  
32 effect until the earlier of either:

33 (1) A ruling by the United States Supreme Court that the  
34 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended  
35 by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111  
36 - 152 is constitutional; or

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(2) November 15, 2011.

(b) The Insurance Commissioner shall not spend any monies given through a federal grant dealing with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111 – 152, unless approved by all appropriate legislative bodies pursuant to existing appropriation requirements, and until the earlier of either:

(1) A ruling by the United States Supreme Court that the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111 – 152 is constitutional; or

(2) November 15, 2011.

(c) Nothing in subsection (b) shall be construed to limit or prevent the commissioner from either spending any portion of the federal grant monies already procured by the State Insurance Department, or attempting to procure additional federal grants prior to the dates specified in subsection (b).

/s/Allen