

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

State of Arkansas
90th General Assembly
Regular Session, 2015

A Bill

HOUSE BILL 1492

By: Representatives Bentley, M. Gray, Lundstrum, Tosh, Ballinger, Beck, Brown, Copeland, Deffenbaugh, C. Douglas, Drown, Farrer, C. Fite, Gates, Gonzales, Gossage, Harris, Henderson, G. Hodges, Jean, Ladyman, Lemons, Lowery, McNair, D. Meeks, S. Meeks, Miller, Payton, Petty, Richmond, Rushing, Scott, B. Smith, Sorvillo, Speaks, Sullivan, Vaught, Wallace, Womack

For An Act To Be Entitled

AN ACT TO REPEAL THE ARKANSAS HEALTH INSURANCE MARKETPLACE ACT; TO REPEAL THE ARKANSAS HEALTH INSURANCE MARKETPLACE LEGISLATIVE OVERSIGHT COMMITTEE; TO AMEND CERTAIN LAWS REFERRING TO THE ARKANSAS HEALTH INSURANCE MARKETPLACE; AND FOR OTHER PURPOSES.

Subtitle

TO REPEAL THE ARKANSAS HEALTH INSURANCE MARKETPLACE ACT; TO REPEAL THE ARKANSAS HEALTH INSURANCE MARKETPLACE LEGISLATIVE OVERSIGHT COMMITTEE; AND TO AMEND CERTAIN LAWS REFERRING TO THE ARKANSAS HEALTH INSURANCE MARKETPLACE.

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

SECTION 1. DO NOT CODIFY. Legislative intent.

It is the intent of the General Assembly that:

(1) The Arkansas Health Insurance Marketplace and the Board of Directors of the Arkansas Health Insurance Marketplace be dissolved as of the effective date of this act;

(2) The functions and duties of the Arkansas Health Insurance Marketplace and the Board of Directors of the Arkansas Health Insurance



Marketplace be terminated on a state-level as of the effective date of this act; and

(3) The State of Arkansas does not create or transition to a state-based exchange or state-based marketplace as authorized under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

SECTION 2. Arkansas Code Title 10, Chapter 3, Subchapter 27, is repealed.

~~Subchapter 27—Arkansas Health Insurance Marketplace Legislative Oversight Committee~~

~~10-3-2701.—Arkansas Health Insurance Marketplace Legislative Oversight Committee.~~

~~(a)—The Arkansas Health Insurance Marketplace Legislative Oversight Committee is established.~~

~~(b)(1)—The Arkansas Health Insurance Marketplace Legislative Oversight Committee shall consist of the following members of the General Assembly appointed as follows:~~

~~(A)—Six (6) members of the House of Representatives shall be appointed to the Arkansas Health Insurance Marketplace Legislative Oversight Committee by the Speaker of the House of Representatives; and~~

~~(B)—Six (6) members of the Senate shall be appointed to the Arkansas Health Insurance Marketplace Legislative Oversight Committee by the President Pro Tempore of the Senate.~~

~~(2)—In making appointments, each appointing officer shall select members who have appropriate experience and knowledge of the issues to be examined by the Arkansas Health Insurance Marketplace Legislative Oversight Committee and may consider racial, gender, and geographical diversity among the membership.~~

~~(c)(1)—The Arkansas Health Insurance Marketplace Legislative Oversight Committee shall study matters pertaining to the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., as the Arkansas Health Insurance Marketplace Legislative Oversight Committee considers necessary to fulfill its mandate.~~

~~(2)—The Arkansas Health Insurance Marketplace Legislative Oversight Committee may request reports from the Arkansas Health Insurance~~

~~Marketplace pertaining to the operations, programs, or finances of the Arkansas Health Insurance Marketplace as it deems necessary.~~

~~(d) Annually by December 15, the Arkansas Health Insurance Marketplace Legislative Oversight Committee shall provide to the General Assembly any analysis or findings resulting from its activities under this section that the Arkansas Health Insurance Marketplace Legislative Oversight Committee deems relevant.~~

~~(e)(1) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Arkansas Health Insurance Marketplace Legislative Oversight Committee.~~

~~(2) The Arkansas Health Insurance Marketplace Legislative Oversight Committee shall meet at least quarterly upon the joint call of the cochairs of the Arkansas Health Insurance Marketplace Legislative Oversight Committee.~~

~~(3) A majority of the Arkansas Health Insurance Marketplace Legislative Oversight Committee constitutes a quorum.~~

~~(4) No action may be taken by the Arkansas Health Insurance Marketplace Legislative Oversight Committee except by a majority vote at a meeting at which a quorum is present.~~

~~(f) Members of the Arkansas Health Insurance Marketplace Legislative Oversight Committee are entitled to per diem and mileage reimbursement at the same rate authorized by law for attendance at meetings of interim committees of the General Assembly and shall be paid from the same source.~~

~~(g)(1) With the consent of both the President Pro Tempore of the Senate and the Speaker of the House of Representatives, the Arkansas Health Insurance Marketplace Legislative Oversight Committee may meet during a session of the General Assembly to perform its duties under this section.~~

~~(2) This subsection does not limit the authority of the Arkansas Health Insurance Marketplace Legislative Oversight Committee to meet during a recess as authorized by § 10-3-211 or § 10-2-223.~~

SECTION 3. Arkansas Code Title 23, Chapter 61, Subchapter 8, is repealed.

~~Subchapter 8—Arkansas Health Insurance Marketplace Act~~

~~23-61-801.—Title.~~

~~This subchapter shall be known and may be cited as the “Arkansas Health Insurance Marketplace Act”.~~

~~23-61-802. Definitions.~~

~~As used in this subchapter:~~

~~(1) “Federal act” means the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments to or regulations or guidance issued under those statutes existing on April 23, 2013;~~

~~(2)(A) “Health benefit plan” means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.~~

~~(B) “Health benefit plan” does not include:~~

~~(i) Coverage only for accident or disability income insurance, or both;~~

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

~~(iii) Liability insurance, including without limitation general liability insurance and automobile liability insurance;~~

~~(iv) Workers’ compensation or similar insurance;~~

~~(v) Automobile medical payment insurance;~~

~~(vi) Credit-only insurance;~~

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

~~(viii) Other similar insurance coverage, specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on April 23, 2013, under which benefits for healthcare services are secondary or incidental to other insurance benefits.~~

~~(C) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:~~

~~(i) Limited scope dental or vision benefits;~~

~~(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or a combination of these; or~~

~~(iii) Other similar limited benefits specified in~~

~~federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on April 23, 2013.~~

~~(D) —“Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:~~

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

~~(ii) —Hospital indemnity or other fixed indemnity insurance.~~

~~(E) —“Health benefit plan” does not include the following if offered as a separate policy, certificate, or contract of insurance:~~

~~(i) —Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, Pub. L. No. 74-271, as existing on April 23, 2013;~~

~~(ii) —Coverage supplemental to the coverage provided to military personnel and their dependents under Chapter 55 of Title 10 of the United States Code and the Civilian Health and Medical Program of the Uniformed Services, 32 C.F.R. Part 199; or~~

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

~~(3) —“Health insurance” means insurance that is primarily for the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure of the body, including transportation that is essential to obtaining health insurance, but excluding:~~

~~(A) —Coverage only for accident or disability income insurance, or any combination thereof;~~

~~(B) —Coverage issued as a supplement to liability insurance;~~

~~(C) —Liability insurance, including general liability~~

~~insurance and automobile liability insurance;~~

~~(D) Workers' compensation or similar insurance;~~

~~(E) Automobile medical payment insurance;~~

~~(F) Credit only insurance;~~

~~(G) Coverage for on-site medical clinics;~~

~~(H) Coverage only for limited scope vision benefits;~~

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

~~(J) Coverage for specified disease or critical illness;~~

~~(K) Hospital indemnity or other fixed indemnity insurance;~~

~~(L) Medicare supplement policies;~~

~~(M) Medicare, Medicaid, or the Federal Employee Health Benefit Program;~~

~~(N) Coverage only for medical and surgical outpatient benefits;~~

~~(O) Excess or stop-loss insurance; and~~

~~(P) Other similar insurance coverage:~~

~~(i) Under which benefits for health insurance are secondary or incidental to other insurance benefits; or~~

~~(ii) Specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on April 23, 2013, under which benefits for healthcare services are secondary or incidental to other insurance benefits;~~

~~(4) "Health insurer" means an entity that provides health insurance or a health benefit plan in the State of Arkansas, including without limitation an insurance company, medical services plan, hospital plan, hospital medical service corporation, health maintenance organization, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;~~

~~(5) "Qualified employer" means a small employer that elects to make its full-time employees eligible for one (1) or more qualified health plans offered through the small business health options program, and at the option of the employer, some or all of its part-time employees, provided that the employer:~~

~~(A) Has its principal place of business in this state and elects to provide coverage through the small business health options program~~

~~to all of its eligible employees, wherever employed; or~~

~~(B) Elects to provide coverage through the small business health options program to all of its eligible employees who are principally employed in this state;~~

~~(6) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the federal act; and~~

~~(7)(A) "Small employer" means an employer that employed an average of not more than fifty (50) employees during the preceding calendar year.~~

~~(B) For purposes of this subdivision (7):~~

~~(i) All persons treated as a single employer under subsection (b), subsection (c), subsection (m), or subsection (o) of section 414 of the Internal Revenue Code of 1986 as existing on April 23, 2013, shall be treated as a single employer;~~

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

~~(iii) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;~~

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

~~(v) An employer that makes enrollment in qualified health plans available to its employees through the small business health options program and would cease to be a small employer because of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this subchapter as long as it continuously makes enrollment through the small business health options program available to its employees.~~

~~23-61-803. Arkansas Health Insurance Marketplace.~~

~~(a) There is created a nonprofit legal entity to be known as the "Arkansas Health Insurance Marketplace".~~

~~(b)(1) The Arkansas Health Insurance Marketplace is created as a political subdivision, instrumentality, and body politic of the State of Arkansas and, as such, is not a state agency.~~

~~(2) Except to the extent provided by this subchapter, the Arkansas Health Insurance Marketplace is exempt from:~~

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

~~(B) All laws other than the Freedom of Information Act of 1967, § 25-19-101 et seq., governing state agencies, including without limitation:~~

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

~~(ii) The Uniform Classification and Compensation Act, § 21-5-201 et seq.; and~~

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

~~(b) The Arkansas Health Insurance Marketplace shall adopt policies, procedures, and rules to implement its obligations under this subchapter.~~

~~(3)(A) Prior to the adoption, amendment, or repeal of any policy, procedure, or rule, the Arkansas Health Insurance Marketplace shall:~~

~~(i)(a) Give at least thirty (30) days' notice of its intended action. The thirty-day period shall begin on the first day of the publication of notice.~~

~~(b) The notice shall include a statement of the terms or substance of the intended action or a description of the subjects and issues involved and the time, the place where, and the manner in which interested persons may present their views on the intended action or the subjects and issues involved.~~

~~(c) The notice shall be mailed to any person specified by law and to all persons who have requested advance notice of rule-making proceedings.~~

~~(d)(1) Unless otherwise provided by law, the notice shall be published in a newspaper of general daily circulation for three (3) consecutive days and, when appropriate, in those trade, industry, or professional publications that the Arkansas Health Insurance Marketplace may select.~~

~~(2) The notice shall be published by the Secretary of State on the Internet for thirty (30) days in accordance with § 25-15-218;~~

~~(ii)(a) Afford all interested persons at least thirty (30) days to submit written data, views, or arguments, orally or in writing. The thirty day period shall begin on the first day of the publication of notice under subdivision (b)(3)(A)(i)(a) of this section.~~

~~(b) Opportunity for oral hearing shall be granted if requested by twenty five (25) persons, by a governmental subdivision or agency, or by an association having no fewer than twenty five (25) members.~~

~~(c) The Arkansas Health Insurance Marketplace shall fully consider all written and oral submissions concerning the proposed rule before finalizing the language of the proposed rule and filing the proposed rule as required by subdivision (b)(3)(E) of this section.~~

~~(d) Upon the adoption, amendment, or repeal of a policy, procedure, or rule, the Arkansas Health Insurance Marketplace, if requested to do so by an interested person either prior to adoption, amendment, or repeal or within thirty (30) days thereafter, shall issue a concise statement of the principal reasons for and against its adoption, amendment, or repeal, incorporating therein its reasons for overruling the considerations urged against its adoption, amendment, or repeal; and~~

~~(iii) Comply with § 25-15-301 et seq. [Repealed].~~

~~(B) The thirty day periods for giving public notice under subdivision (b)(3)(A)(i)(a) of this section and for receiving written data, views, or arguments, orally or in writing, under subdivision (b)(3)(A)(ii)(a) of this section shall run concurrently.~~

~~(C)(i) If the Arkansas Health Insurance Marketplace finds that imminent peril to the public health, safety, or welfare or compliance with federal laws or regulations requires adoption of a policy, procedure, or rule upon less than thirty (30) days' notice and states in writing its reasons for that finding, it may proceed without prior notice or hearing, or upon any abbreviated notice and hearing that it may choose, to adopt an emergency rule.~~

~~(ii) The rule may be effective for no longer than one hundred twenty (120) days.~~

~~(iii) If, after the expiration of the effective period of an emergency rule, the Arkansas Health Insurance Marketplace wishes to adopt a successive emergency rule that is identical or substantially similar to the expired emergency rule, the Arkansas Health Insurance Marketplace shall not adopt the successive emergency rule earlier than thirty (30) days after the expiration of the emergency rule.~~

~~(D)(i) The Arkansas Health Insurance Marketplace shall file with the Arkansas Health Insurance Marketplace Legislative Oversight Committee, the Secretary of State, the Arkansas State Library, and the Bureau of Legislative Research a copy of each policy, procedure, or rule adopted by it and a statement of financial impact for the rule.~~

~~(ii) The Secretary of State shall keep a copy of each policy, procedure, or rule filed under subdivision (b)(3)(D)(i) of this section in the permanent register required under § 25-15-204(d)(2).~~

~~(iii)(a) The scope of the financial impact statement shall be determined by the Arkansas Health Insurance Marketplace but, at a minimum, shall include the estimated cost of complying with the policy, procedure, or rule and the estimated cost for the Arkansas Health Insurance Marketplace to implement the policy, procedure, or rule.~~

~~(b) If the Arkansas Health Insurance Marketplace has reason to believe that the development of a financial impact statement will be so speculative as to be cost prohibitive, the Arkansas Health Insurance Marketplace shall submit a statement and explanation to that effect.~~

~~(c) If the purpose of an Arkansas Health Insurance Marketplace policy, procedure, or rule is to implement a federal rule or regulation, the financial impact statement shall be limited to any incremental additional cost of the state policy, procedure, or rule, as opposed to the federal rule or regulation.~~

~~(E)(i)(a) Each policy, procedure, or rule adopted by the Arkansas Health Insurance Marketplace is effective thirty (30) days after the filing of the final policy, procedure, or rule unless a later date is specified by law or in the rule itself.~~

~~(b) A final rule shall not be filed until the thirty day public comment period required under subdivision (b)(3)(A)(ii)(a) of this section has expired.~~

~~(c)(1) After the expiration of the thirty-day public comment period and before the effective date of the rule, the Arkansas Health Insurance Marketplace shall take appropriate measures to make the final rule known to the persons who may be affected by the rule.~~

~~(2) Appropriate measures shall include without limitation posting the following information on the Arkansas Health Insurance Marketplace's website:~~

~~(A) The final rule;~~

~~(B) Copies of all written comments submitted to the Arkansas Health Insurance Marketplace regarding the rule;~~

~~(C) A summary of all written and oral comments submitted to the Arkansas Health Insurance Marketplace regarding the rule and the Arkansas Health Insurance Marketplace's response to those comments; and~~

~~(D) The proposed effective date of the final rule.~~

~~(ii)(a) However, an emergency rule may become effective immediately upon filing or at a stated time less than thirty (30) days after filing if the Arkansas Health Insurance Marketplace finds that this effective date is necessary because of imminent peril to the public health, safety, or welfare.~~

~~(b) The Arkansas Health Insurance Marketplace's finding and a brief statement of the reasons for the finding shall be filed with the rule.~~

~~(c) The Arkansas Health Insurance Marketplace shall take appropriate measures to make emergency rules known to the persons who may be affected by the emergency rules.~~

~~(F) The Arkansas Health Insurance Marketplace Legislative Oversight Committee shall review the proposed revised or amended policy, procedure, or rule and, if it is believed that the rule or regulation is contrary to legislative intent, shall file a statement thereof with the Legislative Council.~~

~~(e) The Arkansas Health Insurance Marketplace shall operate subject to the supervision and control of the Board of Directors of the Arkansas Health Insurance Marketplace. The board shall consist of the following members to be appointed on or before July 1, 2013:~~

~~(1)(A) Three (3) members appointed by the Governor.~~

~~(B) One (1) member appointed by the Governor shall be a representative of insurance agents or brokers licensed to sell health insurance in the State of Arkansas.~~

~~(C) Two (2) members appointed by the Governor shall be consumer representatives;~~

~~(2)(A) Three (3) members appointed by the President Pro Tempore of the Senate.~~

~~(B) One (1) of the members appointed by the President Pro Tempore of the Senate shall be a representative of a health insurer.~~

~~(C) One (1) of the members appointed by the President Pro Tempore of the Senate shall be a representative of small employers;~~

~~(3)(A) Three (3) members appointed by the Speaker of the House of Representatives.~~

~~(B) One (1) of the members appointed by the Speaker of the House of Representatives shall be a representative of a health insurer.~~

~~(C) One (1) member appointed by the Speaker of the House of Representatives shall be a member of a health-related profession licensed in the State of Arkansas;~~

~~(4) The Insurance Commissioner or his or her designee; and~~

~~(5) The Director of the Department of Human Services or his or her designee.~~

~~(d)(1)(A) The initial members appointed by the Governor under subdivision (c)(1) of this section shall serve terms as follows:~~

~~(i) One (1) initial member shall be appointed to a term of four (4) years;~~

~~(ii) One (1) initial member shall be appointed to a term of six (6) years; and~~

~~(iii) One (1) initial member shall be appointed to a term of eight (8) years.~~

~~(B) A member subsequently appointed to the board under subdivision (c)(1) of this section shall serve a term of six (6) years.~~

~~(2)(A) The initial members appointed by the President Pro Tempore of the Senate under subdivision (c)(2) of this section shall serve terms as follows:~~

~~(i) One (1) initial member shall be appointed to a~~

~~term of four (4) years;~~

~~(ii) One (1) initial member shall be appointed to a term of six (6) years; and~~

~~(iii) One (1) initial member shall be appointed to a term of eight (8) years.~~

~~(B) A member subsequently appointed to the board under subdivision (c)(2) of this section shall serve a term of six (6) years.~~

~~(3)(A) The initial members appointed by the Speaker of the House of Representatives under subdivision (c)(3) of this section shall serve terms as follows:~~

~~(i) One (1) initial member shall be appointed to a term of four (4) years;~~

~~(ii) One (1) initial member shall be appointed to a term of six (6) years; and~~

~~(iii) One (1) initial member shall be appointed to a term of eight (8) years.~~

~~(B) A member subsequently appointed to the board under subdivision (c)(3) of this section shall serve a term of six (6) years.~~

~~(c) The appointing authorities under this section shall ensure that a majority of the voting members of the board have relevant experience in:~~

~~(1) Health benefits administration;~~

~~(2) Healthcare finance;~~

~~(3) Health plan purchasing;~~

~~(4) Healthcare delivery system administration; or~~

~~(5) Public health or health policy issues related to the small group and individual markets and the uninsured.~~

~~(f) The board shall select one (1) of its members as chair.~~

~~(g)(1) Subject to review by the Arkansas Health Insurance Marketplace Legislative Oversight Committee, the board may authorize by a majority vote of the total membership of the board cast during its first regularly scheduled meeting of each calendar year:~~

~~(A) Payment to its members of a stipend per day not to exceed one hundred dollars (\$100) for each meeting attended or for any day while performing substantive business of the board; and~~

~~(B) Reimbursement of actual expenses while performing substantive business of the board.~~

~~(2) Members of the board shall receive no other compensation, expense reimbursement, or in lieu of payments.~~

~~(h)(1) The board shall hire the Executive Director of the Arkansas Health Insurance Marketplace to:~~

~~(A) Plan and administer the Arkansas Health Insurance Marketplace; and~~

~~(B) Employ necessary staff.~~

~~(2) The board may plan and administer the Arkansas Health Insurance Marketplace and employ necessary staff on an interim basis until the executive director is hired.~~

~~(3) The employees of the Arkansas Health Insurance Marketplace are not eligible to participate in the Arkansas Public Employees' Retirement System under § 24-4-101 et seq.~~

~~(i)(1) Neither the board nor its employees shall be liable for any obligations of the Arkansas Health Insurance Marketplace.~~

~~(2) The board may provide in its bylaws or rules for indemnification of and legal representation for the board members and board employees.~~

~~(j)(1) The board shall adopt articles, bylaws, and operating rules in accordance with this subchapter within ninety (90) days after the appointment of the board.~~

~~(2) The articles, bylaws, and operating rules shall be reviewed by the Arkansas Health Insurance Marketplace Legislative Oversight Committee.~~

~~(k) The board shall keep an accurate accounting of all activities, receipts, and expenditures on behalf of the Arkansas Health Insurance Marketplace and report to the Arkansas Health Insurance Marketplace Legislative Oversight Committee as requested by the Arkansas Health Insurance Marketplace Legislative Oversight Committee.~~

~~(l)(1)(A) On and after July 1, 2015, the board shall have the authority to apply for and expend on behalf of the Arkansas Health Insurance Marketplace any state, federal, or private grant funds available to assist with the implementation and operation of the Arkansas Health Insurance Marketplace.~~

~~(B) Before July 1, 2015, the board shall coordinate with the Insurance Commissioner the application for state, federal, or private grant funds to plan, implement, and operate the Arkansas Health Insurance~~

Marketplace.

~~(2)(A) Before July 1, 2015, the Insurance Commissioner may apply for any state, federal, or private grant funds available to assist with the implementation and operation of the Arkansas Health Insurance Marketplace.~~

~~(B) If the Insurance Commissioner applies for and receives any state, federal, or private grant funds available to assist with the implementation and operation of the Arkansas Health Insurance Marketplace, the Insurance Commissioner shall enter into a memorandum of understanding with the Arkansas Health Insurance Marketplace concerning the use and expenditure of the grant funds.~~

~~(m)(1) The board may contract with eligible entities to assist with the planning, implementation, and operation of the Arkansas Health Insurance Marketplace.~~

~~(2) For purposes of this subsection:~~

~~(A) An eligible entity includes without limitation an entity that has experience in individual and small group health insurance, benefit administration, or other experience relevant to the responsibilities to be assumed by the entity; and~~

~~(B) A health insurer or an affiliate of a health insurer is not an eligible entity.~~

~~(3) In contracting with an eligible entity under subdivision (m)(1) of this section, the board shall give preference to eligible entities that have relevant experience.~~

~~(4)(A) The board shall establish a competitive bidding process for awarding contracts under this subchapter to an eligible entity.~~

~~(B) The competitive bidding process for awarding contracts under this subchapter to an eligible entity shall be reviewed by the Arkansas Health Insurance Marketplace Legislative Oversight Committee.~~

~~(n) The board may enter into information-sharing agreements with federal and state agencies and other state marketplaces to carry out its responsibilities under this subchapter, provided such agreements:~~

~~(1) Include adequate protections with respect to the confidentiality of the information to be shared; and~~

~~(2) Comply with all applicable state and federal laws and regulations.~~

~~(o) As a condition of participating in the Arkansas Health Insurance~~

~~Marketplace, a health insurer shall pay the assessments, submit the reports, and provide the information required by the board or the Insurance Commissioner to implement this subchapter.~~

~~(p) The board and any eligible entity under subdivision (m)(1) of this section shall provide claims and other plan and enrollment data to the Department of Human Services and the Insurance Commissioner upon request to:~~

~~(1) Facilitate compliance with reporting requirements under state and federal law; and~~

~~(2) Assess the performance of the Health Care Independence Program established by the Health Care Independence Act of 2013, § 20-77-2401 et seq., if enacted, including without limitation the program's quality, cost, and consumer access.~~

~~23-61-804. Duties of Arkansas Health Insurance Marketplace.~~

~~The Arkansas Health Insurance Marketplace shall:~~

~~(1)(A) Implement procedures and criteria for the certification, recertification, and decertification of health benefit plans as qualified health plans in coordination with the Insurance Commissioner and in compliance with state and federal law.~~

~~(B) The procedures and criteria shall comply with applicable:~~

~~(i) Federal law;~~

~~(ii) Federal waivers obtained by the state to implement the Health Care Independence Program established by the Health Care Independence Act of 2013, § 20-77-2401 et seq., if enacted; and~~

~~(iii) Rules promulgated by the State Insurance Department and the Department of Human Services under the Health Care Independence Act of 2013, § 20-77-2401 et seq., if enacted;~~

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

~~(3) Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;~~

~~(4) Assign a rating to each qualified health plan offered through the Arkansas Health Insurance Marketplace and determine each qualified health plan's level of coverage in accordance with regulations~~

~~issued by the Secretary of the United States Department of Health and Human Services under section 1302(d)(2)(A) of the federal act;~~

~~(5) Use a standardized format for presenting health benefit options in the Arkansas Health Insurance Marketplace;~~

~~(6) Review compensation rates for licensed brokers and agents;~~

~~(7) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of a premium tax credit under section 36B of the Internal Revenue Code of 1986 as existing on April 23, 2013, and any cost-sharing reduction under section 1402 of the federal act;~~

~~(8)(A) Establish a small business health options program through which qualified employers may access coverage for their employees.~~

~~(B) The small business health options program, without limitation, shall enable a qualified employer to specify a level of coverage so that any of its employees may enroll in a qualified health plan offered through the program at the specified level of coverage;~~

~~(9) Subject to section 1411 of the federal act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986 as existing on April 23, 2013, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section of the Internal Revenue Code of 1986 because:~~

~~(A) There is no affordable qualified health plan available through the Arkansas Health Insurance Marketplace or the individual's employer covering the individual; or~~

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

~~(10) Transfer to the Secretary of the United States Department of the Treasury the following:~~

~~(A) A list of the individuals who are issued a certification under subdivision (9) of this section, including the name and taxpayer identification number of each individual;~~

~~(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 as existing on April 23, 2013, because:~~

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

~~(ii) The employer provided the minimum essential coverage, but it was determined under section 36B(e)(2)(C) of the Internal Revenue Code of 1986 as existing on April 23, 2013, either to be unaffordable to the employee or not to provide the required minimum actuarial value; and~~

~~(C) The name and taxpayer identification number of each individual who:~~

~~(i) Notifies the Arkansas Health Insurance Marketplace under section 1411(b)(4) of the federal act that he or she has changed employers; and~~

~~(ii) Ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;~~

~~(11) Provide to each employer the name of each employee of the employer described in subdivision (10)(B) of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;~~

~~(12)(A) Select entities qualified to serve as navigators and award grants to enable navigators to:~~

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

~~(ii) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 as existing on April 23, 2013, and cost-sharing reductions under section 1402 of the federal act;~~

~~(iii) Facilitate enrollment in qualified health plans;~~

~~(iv) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or to any other appropriate state agency or agencies for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan or health benefit coverage or a determination under his or her health benefit plan or health benefit coverage; and~~

~~(v) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population~~

~~being served by the Arkansas Health Insurance Marketplace.~~

~~(B) The board shall ensure in the navigator selection process that the navigators are geographically, culturally, ethnically, and racially representative of the populations served; and~~

~~(13) Otherwise comply with a requirement the board determines is necessary to obtain or maintain the approval to establish or administer a state-based health insurance marketplace.~~

~~23-61-805. Funding—Publication of costs.~~

~~(a)(1) The General Assembly shall establish a reasonable initial assessment or user fee and reasonable increases or decreases in the amount of future assessments or user fees and penalties and interest charges for nonpayment of an assessment or user fee charged to participating health insurers for the efficient operation of the Arkansas Health Insurance Marketplace.~~

~~(2) Beginning October 1, 2014, and annually by October 1 thereafter, the Arkansas Health Insurance Marketplace shall report to the Arkansas Health Insurance Marketplace Legislative Oversight Committee in the manner and format that the committee requires the Arkansas Health Insurance Marketplace's recommendations for the initial assessment or user fee and increases or decreases in the amount of future assessments or user fees and penalties and interest charges for nonpayment of an assessment or user fee charged to participating health insurers.~~

~~(3) Beginning January 1, 2015, and annually by January 1 thereafter, the Arkansas Health Insurance Marketplace Legislative Oversight Committee shall review the recommendations of the Arkansas Health Insurance Marketplace under subdivision (a)(1) of this section and report to the President Pro Tempore of the Senate and the Speaker of the House of Representatives the committee's recommendations for the initial assessment or user fee and future increases or decreases in the amount of assessments or user fees and penalties and interest charges for nonpayment of an assessment or user fee charged to participating health insurers.~~

~~(b)(1) An assessment may be offset in an amount equal to the amount of the assessment paid to the Arkansas Health Insurance Marketplace against the premium tax payable for the year in which the assessment is levied.~~

~~(2) An offset shall not be allowed for a penalty assessed under~~

~~subsection (c) of this section.~~

~~(c)(1) All assessments and fees shall be due and payable upon receipt and shall be delinquent if not paid within thirty (30) days of the receipt of notice of the assessment by the health insurer.~~

~~(2)(A) Failure to timely pay the assessment shall automatically subject the health insurer to a penalty not to exceed ten percent (10%) of the assessment plus interest as established under subsection (a) of this section.~~

~~(B) The penalty and interest is due and payable within the next thirty day period.~~

~~(3) The Board of Directors of the Arkansas Health Insurance Marketplace and the Insurance Commissioner may enforce the collection of the assessment and penalty and interest in accordance with this subchapter and the Arkansas Insurance Code.~~

~~(4) The board may waive the penalty and interest authorized by this subsection if the board determines that compelling circumstances exist that justify a waiver.~~

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

~~(2) Information published under subdivision (d)(1) of this section shall include information on moneys lost to waste, fraud, and abuse.~~

~~23-61-806. Rules.~~

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

~~(b) Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary of the United States Department of Health and Human Services under the federal act.~~

~~23-61-807. Relation to other laws.~~

~~(a) This subchapter is amendatory to the Arkansas Insurance Code.~~

~~(b) Provisions of the Arkansas Insurance Code that are not in conflict with this subchapter are applicable to this subchapter.~~

~~(c) This subchapter and actions taken by the Arkansas Health Insurance Marketplace under this subchapter shall not be construed to preempt or supersede the authority of the Insurance Commissioner to regulate the business of insurance within this state.~~

~~(d) Except as expressly provided to the contrary in this subchapter, a health insurer offering a qualified health plan in this state shall comply fully with all applicable health insurance laws of this state and regulations adopted and orders issued by the commissioner.~~

SECTION 4. Arkansas Code Title 23, Chapter 64, Subchapter 6, is repealed.

~~Subchapter 6—Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act [Contingent effective date.]~~

~~23-64-601.—Title. [Contingent effective date.]~~

~~This subchapter shall be known and may be cited as the “Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act”.~~

~~23-64-602.—Definitions. [Contingent effective date.]~~

~~As used in this subchapter:~~

~~(1) “Applicant” means a person who has applied to become licensed under this subchapter as a navigator, guide, certified application counselor, or certified licensed producer;~~

~~(2) “Certified application counselor” means a person who is licensed under this subchapter to assist in enrolling consumers in a variety of marketplace-designated organizations settings, including without limitation a healthcare facility, but is not compensated by federal marketplace funds;~~

~~(3) “Certified licensed producer” means a person who is:~~

~~(A) Licensed as an insurance producer as defined in § 23-64-502;~~

~~(B) Certified under this subchapter to:~~

~~(i) Educate consumers about health insurance marketplaces, Medicaid, tax credits, and other cost-sharing reductions; and~~

~~(ii) Assist consumers with enrollment in a health~~

~~insurance marketplace;~~

~~(C) Eligible to receive commissions from health insurers;~~

~~and~~

~~(D) Not compensated under the federal act, federal regulations, or any guidance issued under the federal act or federal regulations;~~

~~(4) "Consumer" means an individual, family, or small business located in this state;~~

~~(5) "Enrollment" means enrolling in a qualified health plan offered through a health insurance marketplace;~~

~~(6) "Federal act" means the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments to or regulations or guidance issued under those statutes existing on the effective date of this act;~~

~~(7) "Guide" means a person who is licensed under this subchapter to provide in-person assistance and services as stated in 45 C.F.R. § 155.210;~~

~~(8)(A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.~~

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

~~(i) Coverage only for accident or disability income insurance, or both;~~

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

~~(iii) Liability insurance, including without limitation general liability insurance and automobile liability insurance;~~

~~(iv) Workers' compensation or similar insurance;~~

~~(v) Automobile medical payment insurance;~~

~~(vi) Credit-only insurance;~~

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

~~(viii) Other similar insurance coverage, specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on the effective date of this act, under which benefits for healthcare services are~~

~~secondary or incidental to other insurance benefits.~~

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

- ~~(i) Limited scope dental or vision benefits;~~
- ~~(ii) Benefits for long term care, nursing home care, home health care, community based care, or a combination of these; or~~
- ~~(iii) Other similar limited benefits specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104 191, and existing on the effective date of this act.~~

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

- ~~(i) Coverage only for a specified disease or illness; or~~
- ~~(ii) Hospital indemnity or other fixed indemnity insurance.~~

~~(E) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:~~

- ~~(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, Pub. L. No. 74-271, as existing on the effective date of this act;~~
- ~~(ii) Coverage supplemental to the coverage provided to military personnel and their dependents under Chapter 55 of Title 10 of the United States Code and the Civilian Health and Medical Program of the Uniformed Services, 32 C.F.R. Part 199; or~~
- ~~(iii) Similar supplemental coverage provided to coverage under a group health plan;~~

~~(9) "Health insurance" means insurance that is primarily for the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts~~

~~paid for the purpose of affecting any structure of the body, including transportation that is essential to obtaining health insurance, but excluding:~~

- ~~(A) Coverage only for accident or disability income insurance, or any combination thereof;~~
- ~~(B) Coverage issued as a supplement to liability insurance;~~
- ~~(C) Liability insurance, including general liability insurance and automobile liability insurance;~~
- ~~(D) Workers' compensation or similar insurance;~~
- ~~(E) Automobile medical payment insurance;~~
- ~~(F) Credit-only insurance;~~
- ~~(G) Coverage for on-site medical clinics;~~
- ~~(H) Coverage only for limited scope vision benefits;~~
- ~~(I) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;~~
- ~~(J) Coverage for specified disease or critical illness;~~
- ~~(K) Hospital indemnity or other fixed indemnity insurance;~~
- ~~(L) Medicare supplement policies;~~
- ~~(M) Medicare, Medicaid, or the Federal Employee Health Benefit Program, 5 U.S.C. §§ 8901—8914, as it existed on January 1, 2013;~~
- ~~(N) Coverage only for medical and surgical outpatient benefits;~~
- ~~(O) Excess or stop loss insurance; and~~
- ~~(P) Other similar insurance coverage:~~
 - ~~(i) Under which benefits for health insurance are secondary or incidental to other insurance benefits; or~~
 - ~~(ii) Specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on the effective date of this act, under which benefits for healthcare services are secondary or incidental to other insurance benefits;~~

~~(10) "Health insurance marketplace" means the vehicle created to help consumers in this state shop for and select health insurance coverage in a way that permits comparison of available qualified health plans based on price, benefits, services, and quality, regardless of its governance~~

structure;

~~(11) “Health insurer” means an entity that provides health insurance or a health benefit plan in this state, including without limitation an insurance company, medical services plan, hospital plan, hospital medical service corporation, health maintenance organization, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits in this state, and is subject to state insurance regulation;~~

~~(12) “License” means a document issued by the Insurance Commissioner authorizing a person to act as a navigator, guide, certified application counselor, or certified licensed producer;~~

~~(13) “Licensee” means a navigator, guide, certified application counselor, or certified licensed producer who is licensed under this subchapter;~~

~~(14) “Navigator” means a person authorized under the federal act to assist consumers to shop for and select health insurance offered through a health insurance marketplace, including providing information to a consumer on a health benefit plan or coverage offered through a health insurance marketplace, or facilitates enrollment in a health insurance marketplace;~~

~~(15) “Non-navigator assistance personnel” means a person authorized under the federal act to assist consumers to enroll and understand the health insurance offered through a health insurance marketplace;~~

~~(16) “Person” means an individual, company, firm, organization, association, corporation, government entity, nongovernmental entity, or any other type of legal entity; and~~

~~(17) “Qualified health plan” means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the federal act.~~

~~23-64-603. Navigator license required. [Contingent effective date.]~~

~~(a)(1) A person shall not act as a navigator in this state through a health insurance marketplace unless licensed under this subchapter as an eligible entity.~~

~~(2) A health insurer or an affiliate of a health insurer is not an eligible entity.~~

~~(b) A grant awarded under a navigator contract is contingent on a~~

~~person's:~~

~~(1) Being licensed under this subchapter;~~

~~(2) Becoming licensed under this subchapter by September 30, 2013, or within ninety (90) days after the receipt of funding; or~~

~~(3) Employing a licensee that meets the requirements in subdivision (b)(1) or subdivision (b)(2) of this section.~~

~~(c) A navigator shall:~~

~~(1) Conduct public education activities to raise awareness of the availability of qualified health plans;~~

~~(2) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 as existing on the effective date of this act and cost-sharing reductions under section 1402 of the federal act;~~

~~(3) Facilitate enrollment in qualified health plans;~~

~~(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or to any other appropriate state agency or agencies for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan, coverage, or a determination under that plan or coverage; and~~

~~(5) Provide enrollment information in a culturally and linguistically appropriate manner that meets the needs of the population being served by a health insurance marketplace in this state, including those individuals with limited English proficiency or who are protected under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 and Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12131-12165, as they existed on January 1, 2013.~~

~~(d) A navigator shall not advise a person to select a particular plan.~~

~~23-64-604. Guide license required. [Contingent effective date.]~~

~~(a)(1) A person shall not act as a guide in this state through a health insurance marketplace unless licensed under this subchapter as an eligible entity.~~

~~(2) A health insurer or an affiliate of a health insurer is not an eligible entity.~~

~~(b) A contract awarded to a guide is contingent on a person's:~~

- ~~(1) Being licensed under this subchapter;~~
- ~~(2) Becoming licensed under this subchapter by September 30, 2013, or within ninety (90) days after the receipt of funding; or~~
- ~~(3) Employing a licensee that meets the requirements in subdivision (b)(1) or subdivision (b)(2) of this section.~~

~~(c) A guide shall:~~

- ~~(1) Assist consumers in understanding the available qualified health plans offered through a health insurance marketplace, their differences, premium tax credits, cost-sharing provisions, and the public programs and their eligibility;~~
- ~~(2) Provide enrollment information in a culturally and linguistically appropriate manner that meets the needs of the population being served by a health insurance marketplace in this state, including those individuals with limited English proficiency or who are protected under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 and Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12131-12165, as they existed on January 1, 2013;~~
- ~~(3) Ensure that information is provided in a way that simplifies choices and considers the individual needs of consumers;~~
- ~~(4) Maintain expertise in eligibility, enrollment, and public and private insurance specifications and conduct public education activities to raise awareness about the health insurance marketplace in this state;~~
- ~~(5) Provide information and services in a fair, accurate, and impartial manner that acknowledges other health programs;~~
- ~~(6) Increase awareness of insurance options in a way that does not stigmatize qualified health plans;~~
- ~~(7) Facilitate enrollment in qualified health plans or coverage offered through a health insurance marketplace and with post-enrollment dispute resolution;~~
- ~~(8) Provide referrals to an applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, 42 U.S.C. § 300gg et seq., as it existed on January 1, 2013, or any other appropriate state agency or agencies, for a consumer participating in enrollment with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under the plan or coverage;~~

~~(9) Not receive any financial consideration directly or indirectly from a health insurer or stop loss insurance company or qualified health plan;~~

~~(10) Demonstrate that no conflict of interest exists in providing in person assistance and the services as stated in 45 C.F.R. § 155.210; and~~

~~(11) Provide resources or avenues for consumers to register complaints and grievances with a service provided through the health insurance marketplace.~~

~~23-64-605. Certified application counselor license required. [Contingent effective date.]~~

~~(a)(1) A person shall not act as a certified application counselor in this state through a health insurance marketplace unless licensed under this subchapter and working for a marketplace-designated organization.~~

~~(2) A health insurer or an affiliate of a health insurer is not an eligible entity.~~

~~(b) A certified application counselor shall assist in enrolling a consumer in a qualified health plan through a health insurance marketplace.~~

~~23-64-606. Licensed producer — Certification required. [Contingent effective date.]~~

~~A person shall not act as a certified licensed producer in this state through a health insurance marketplace unless certified under this subchapter.~~

~~23-64-607. Qualifications for licensure or certification — Issuance. [Contingent effective date.]~~

~~(a) To qualify for a license or certification under this subchapter, a person shall:~~

~~(1) Be at least eighteen (18) years of age;~~

~~(2) Have received a high school diploma or a general education development certificate;~~

~~(3) Be competent, trustworthy, financially responsible, and of good personal and business reputation;~~

~~(4) Continue the qualifications under subdivision (a)(3) of this~~

~~section while licensed or certified;~~

~~(5)(A) Pass an examination and satisfy the educational requirements the Insurance Commissioner may impose by rule or order.~~

~~(B) The examination required by this section shall be developed and conducted under rules prescribed by the commissioner;~~

~~(6)(A) Have received instruction in health insurance, the provisions of the federal act for a health insurance marketplace in this state, and the medical assistance programs of this state.~~

~~(B) The instruction required by this section shall be developed and conducted under rules prescribed by the commissioner; and~~

~~(7) For a certified licensed producer, be a licensee in good standing under the Producer Licensing Model Act, § 23-64-501 et seq.~~

~~(b) In addition to the other information required under this subchapter or rules adopted by the commissioner, an application for a license or certification under this subchapter shall include:~~

~~(1) The applicant's business name, address, and social security number or taxpayer identification number;~~

~~(2) A criminal and regulatory background check of the applicant; and~~

~~(3) A description of the applicant's current business operations and its activities, duties, and responsibilities, including without limitation:~~

~~(A) The place of organization and a certified copy of the applicant's organizational and governance documents;~~

~~(B) If a foreign business, a copy of the certificate of authority from the Secretary of State;~~

~~(C) The proposed method of business operation and, if applicable, other locations for doing business; and~~

~~(D)(i) The qualifications, business experience and history, and financial condition of the applicant, its affiliates, and its employees.~~

~~(ii) Information required under subdivision (b)(3)(D)(i) of this section shall include:~~

~~(a) A description of any injunction or administrative order, including a denial to engage in a regulated activity by a state or federal authority that had jurisdiction over the applicant, its~~

~~affiliates, and its employees;~~

~~(b) A conviction of a misdemeanor involving fraudulent dealings or moral turpitude or relating to any aspect of the insurance industry, the mortgage industry, the securities industry, or any other activity pertaining to financial services;~~

~~(c) Any felony conviction; and~~

~~(d) A beneficial interest in an affiliated industry business.~~

~~(e) Each applicant shall pay a reasonable annual licensure or certification fee as established by rule of the commissioner.~~

~~(d) Each license or certification issued by the commissioner under this subchapter expires at the close of business on September 30 of the calendar year unless otherwise surrendered or revoked.~~

~~(e) A license or certification issued under this subchapter is not transferable.~~

~~(f) To assist in the performance of the commissioner's duties, the commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners or any affiliates or subsidiaries that the National Association of Insurance Commissioners oversees, to perform any ministerial functions that the commissioner and the nongovernmental business may consider appropriate, including the collection of the annual fee for licensure or certification of a navigator, guide, certified application counselor, or certified licensed producer.~~

~~23-64-608. License renewal. [Contingent effective date.]~~

~~(a) A licensee shall submit an application for renewal of a license or certification issued under this subchapter in a form prescribed by the Insurance Commissioner.~~

~~(b) An applicant for a license or certification renewal is required to complete continuing education as prescribed by rule of the commissioner.~~

~~(c) Each licensee shall pay a reasonable annual licensure or certification fee as established by rule of the commissioner.~~

~~23-64-609. Additional licensee duties. [Contingent effective date.]~~

~~(a) A licensee is subject to the insurance laws of this state, including those concerning privacy, market conduct, and unfair trade~~

~~practices acts.~~

~~(b) A licensee shall:~~

~~(1) Comply with other consumer protection and market conduct standards that the Insurance Commissioner considers necessary; and~~

~~(2) Counsel enrollees in the health insurance marketplace in this state about options in Medicaid, the federal Children's Health Insurance Program, and other health insurance coverage.~~

~~23-64-610. Prohibited activities. [Contingent effective date.]~~

~~(a) Except for a certified licensed producer, a licensee shall not:~~

~~(1) Receive compensation directly or indirectly from any health insurer;~~

~~(2) Engage in an activity that requires licensing as a residential insurance producer under the Producer Licensing Model Act, § 23-64-501 et seq.; or~~

~~(3) Recommend a particular plan or advise consumers about which plan to choose.~~

~~(b) A licensee shall not engage in improper conduct, commit fraud, or violate marketplace and consumer protection requirements of this state.~~

~~23-64-611. Disciplinary authority. [Contingent effective date.]~~

~~(a) The Insurance Commissioner by order may deny, suspend, revoke, or refuse to issue or renew a license of a licensee or applicant under this subchapter or may restrict or limit the activities of a licensee if the commissioner finds that:~~

~~(1) The order is in the public interest; and~~

~~(2) A licensee or applicant:~~

~~(A) Has filed an application for an initial license or a renewal of a license that as of its effective date or as of any date after the filing of the application, contains an omission or statement that in light of the circumstances under which it was made is false or misleading with respect to any material fact;~~

~~(B) Has violated or failed to comply with this subchapter, the insurance laws of this state, any rule adopted by the commissioner, or any order of the commissioner issued under this subchapter;~~

~~(C) Has pleaded guilty or nolo contendere to or has been~~

~~found guilty in a domestic, foreign, or military court of:~~

~~(i) A felony;~~

~~(ii) An offense involving breach of trust, moral turpitude, money laundering, or fraudulent or dishonest dealing; or~~

~~(iii) An offense involving any aspect of the insurance business, the mortgage industry, the securities industry, or any other activity pertaining to financial services;~~

~~(D) Is permanently or temporarily enjoined by a court of competent jurisdiction from engaging in or continuing any conduct or practice involving any aspect of the insurance business, the mortgage industry, the securities industry, or any other activity pertaining to financial services;~~

~~(E) Is the subject of an order of the commissioner:~~

~~(i) Denying, suspending, revoking, restricting, or limiting a license issued under the insurance laws of this state; or~~

~~(ii) Directing the licensee or applicant to cease and desist an activity regulated by the commissioner;~~

~~(F) Is the subject of an order, including a denial, suspension, or revocation of authority to engage in a regulated activity by another state or federal authority to which the licensee or applicant is, has been, or has sought to be subject, entered in the past five (5) years, including without limitation the insurance industry;~~

~~(G)(i) Has failed to pay the proper fees as established by rule of the commissioner.~~

~~(ii) The commissioner may enter a denial order against a licensee or applicant under subdivision (a)(2)(G)(i) of this section if the licensee or applicant fails to pay the proper fees as established by rule of the commissioner, but the denial order shall be vacated by the commissioner if the fees are paid;~~

~~(H) Has engaged in fraudulent, coercive, or dishonest practices or demonstrated incompetence, untrustworthiness, lack of good personal or business reputation, or financial irresponsibility;~~

~~(I) Has forged another's name to an application for insurance or to any document related to an insurance transaction;~~

~~(J) Has improperly used notes or any other reference material to complete an examination for an insurance license;~~

~~(K) Has failed to provide a written response within thirty~~

~~(30) days after receipt of a written inquiry from the commissioner or the commissioner's designee concerning transactions unless the commissioner waives the requirement of a timely response in writing;~~

~~(L) Has failed to comply with an administrative or court order imposing a child support obligation;~~

~~(M) Has failed to pay state income tax or comply with an administrative or court order directing payment of state income tax;~~

~~(N) Has refused to be examined or to produce an account, record, or file for examination at the request of the commissioner or the commissioner's designee; or~~

~~(O) Has failed to cooperate with the commissioner in an investigation.~~

~~(b) The commissioner by order may:~~

~~(1)(A) Impose a civil penalty on a licensee for a violation of this subchapter, the insurance laws of this state, a rule under this subchapter, or an order of the commissioner.~~

~~(B) The civil penalty shall not exceed ten thousand dollars (\$10,000) for each violation under subdivision (b)(1)(A) of this section by a licensee;~~

~~(2) Summarily postpone or suspend the license of a licensee pending a final determination of a proceeding under this section; and~~

~~(3) Change or vacate an order or extend it until a final determination of a proceeding under this section if a hearing is requested or ordered by the commissioner.~~

~~(c) On entering an order under subdivision (b)(1) or subdivision (b)(2) of this section, the commissioner shall:~~

~~(1) Promptly notify the licensee by sending notice of the order and the reasons for issuing the order to the address of the licensee on file with the commissioner by first class mail, postage prepaid; and~~

~~(2)(A) Schedule a hearing under § 23-61-301 et seq. if a licensee contests the order.~~

~~(B) The licensee may contest an order entered under subdivision (b)(1) or subdivision (b)(2) of this section by delivering a written request for a hearing to the commissioner within thirty (30) days after the date on which notice of the order is sent by the commissioner.~~

~~(C)(i) The hearing shall be held within thirty (30) days~~

~~after the commissioner receives a timely written request for a hearing.~~

~~(ii) At the request of the licensee, the hearing may be postponed for a reasonable amount of time.~~

~~(D) If a licensee does not request a hearing and the commissioner does not order a hearing, the order shall remain in effect until the order is modified or vacated by the commissioner.~~

~~(d) The commissioner by order may cancel a license or application if the commissioner finds that a licensee or applicant:~~

~~(1) Is no longer in existence;~~

~~(2) Has stopped doing business as a licensee;~~

~~(3) Is subject to an adjudication of mental incompetence or to the control of a committee, conservator, or guardian; or~~

~~(4) Cannot be located after a reasonable search by the commissioner.~~

~~(e)(1) In addition to other powers under this subchapter, on finding that an action of a person is in violation of this subchapter, the commissioner may summarily order the person to cease and desist the prohibited action.~~

~~(2) On entering the order under subdivision (e)(1) of this section, the commissioner shall:~~

~~(A) Promptly notify the person by sending notice of the order and the reasons for issuing the order to the last known address of the person by first class mail, postage prepaid; and~~

~~(B)(i) Schedule a hearing under § 23-61-301 et seq. if the person contests the order.~~

~~(ii) The person may contest an order entered under subdivision (e)(1) of this section by delivering a written request for a hearing to the commissioner within thirty (30) days after the date on which notice of the order is sent by the commissioner.~~

~~(iii)(a) The hearing shall be held within thirty (30) days after the commissioner receives a timely written request for a hearing.~~

~~(b) At the request of the person, the hearing may be postponed for a reasonable amount of time.~~

~~(iv) If a person does not request a hearing and the commissioner does not order a hearing, the order shall remain in effect until~~

~~it is modified or vacated by the commissioner.~~

~~(3)(A) A person is subject to a civil penalty of up to twenty-five thousand dollars (\$25,000) for each violation of the commissioner's cease and desist order committed after entry of the order if:~~

~~(i) The person under the cease and desist order fails to appeal the order under § 23-61-307 or if the person appeals and the appeal is denied or dismissed; and~~

~~(ii) The person continues to engage in the prohibited action in violation of the commissioner's order.~~

~~(B) The commissioner may file an action requesting the civil penalty under subdivision (c)(3)(A) of this section with the Pulaski County Circuit Court or another court of competent jurisdiction.~~

~~(C) The penalties of this section apply in addition to, but not instead of, other applicable law to a person for the person's failure to comply with an order of the commissioner.~~

~~(f) Unless otherwise provided, an action, hearing, or other proceeding under this subchapter is governed by § 23-61-301 et seq.~~

~~(g) If the commissioner has grounds to believe that a licensee has violated this subchapter or that facts exist that would be the basis for an order against a licensee, the commissioner or the commissioner's designee may investigate or examine the business of the licensee and examine the books, accounts, records, and files of a licensee relating to the complaint or matter under investigation.~~

~~(h)(1) The commissioner or the commissioner's designee may:~~

~~(A) Administer oaths and affirmations;~~

~~(B) Issue subpoenas to require the attendance of and to take testimony of a person whose testimony the commissioner considers relevant to the licensee's business; and~~

~~(C) Issue subpoenas to require the production of the books, papers, correspondence, memoranda, agreements, or other documents or records that the commissioner considers relevant or material to the inquiry.~~

~~(2)(A) When there is contumacy by or refusal to obey a subpoena issued to a licensee or applicant, the Pulaski County Circuit Court, on application by the commissioner, may issue an order requiring the person to appear before the commissioner or the commissioner's designee to produce evidence if so ordered or to give evidence touching the matter under~~

~~investigation or in question.~~

~~(B) Failure to obey the order of the court may be punished by the court as a contempt of court.~~

~~(3) The assertion that the testimony or evidence before the commissioner may tend to incriminate or subject a person to a penalty or forfeiture shall not under § 23-61-302 excuse the person from:~~

~~(A) Attending and testifying;~~

~~(B) Producing any document or record; or~~

~~(C) Obeying the subpoena of the commissioner or the commissioner's designee.~~

~~(i) From time to time and with or without cause, the commissioner may conduct examinations of the books and records of a licensee or applicant to determine the compliance with this subchapter and the rules adopted under this subchapter.~~

~~(j) This section does not prohibit or restrict the informal disposition of a proceeding or allegations that may give rise to a proceeding by stipulation, settlement, consent, or default instead of a formal or informal hearing on the allegations or in place of the sanctions authorized by this section.~~

~~(k)(1) If it appears on sufficient grounds or evidence satisfactory to the commissioner that a person has engaged in or is about to engage in an act or practice that violates this subchapter, the commissioner may:~~

~~(A) Refer the evidence that is available concerning violations of this subchapter or a rule or order issued under this subchapter to the prosecuting attorney or regulatory agency that with or without the referral may otherwise begin criminal or regulatory proceedings under this subchapter; and~~

~~(B)(i) Summarily order the person to stop the act or practice under subsections (b) and (c) of this section and apply to the Pulaski County Circuit Court to enjoin the act or practice or to enforce compliance with this subchapter, rule, or order issued under this subchapter, or both.~~

~~(ii) The commissioner, without issuing a cease and desist order, may apply directly to the Pulaski County Circuit Court for injunctive or other relief.~~

~~(2) On proper showing, the court shall grant a permanent or~~

~~temporary injunction, restraining order, or writ of mandamus.~~

~~(3) The commissioner may also seek and on proper showing the appropriate court shall grant any other ancillary relief that may be in the public interest, including:~~

~~(A) The appointment of a receiver, temporary receiver, or conservator;~~

~~(B) A declaratory judgment;~~

~~(C) An accounting;~~

~~(D) Disgorgement;~~

~~(E) Assessment of a fine of not more than ten thousand dollars (\$10,000) for each violation; and~~

~~(F) Any other relief as may be appropriate in the public interest.~~

~~(4) The court shall not require the commissioner to post a bond.~~

~~23-64-612. Authority—Grants and contracts. [Contingent effective date.]~~

~~(a) The health insurance marketplace in this state may accept grants or contract with a governmental or nongovernmental entity that uses navigators or guides on the conditions the health insurance marketplace finds to be in the best interest of the citizens of this state if the governmental or nongovernmental entity:~~

~~(1) Has a physical business location to conduct business with this state and its service area;~~

~~(2) Is considered to be competent, trustworthy, financially responsible, and of a good business reputation;~~

~~(3) Continues the qualifications under subdivision (a)(2) of this section during the contract;~~

~~(4) Requires the members of management of the governmental or nongovernmental entity to complete instruction in health benefit plans or health insurance, the provisions of the federal act for a health insurance marketplace in this state, and the medical assistance programs of this state through a training program approved by the Insurance Commissioner for the required minimum hours; and~~

~~(5) Furnishes to the commissioner information concerning the identity and background of the members of management of the governmental or~~

~~nongovernmental entity, including criminal and regulatory background checks.~~

~~(b) Each nongovernmental business entity shall pay a reasonable annual licensure fee that is established by rule.~~

~~(c) A grant or contract under this section is not transferable.~~

~~23-64-613. Rules. [Contingent effective date.]~~

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

~~(b) Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary of the United States Department of Health and Human Services under the federal act.~~

~~23-64-614. Relation to other laws. [Contingent effective date.]~~

~~(a) This subchapter is amendatory to the Arkansas Insurance Code.~~

~~(b) Provisions of the Arkansas Insurance Code that are not in conflict with this subchapter apply to this subchapter.~~

~~(c) This subchapter and actions taken by the health insurance marketplace in this state under this subchapter do not preempt or supersede the authority of the Insurance Commissioner to regulate the business of insurance within this state.~~

~~(d) Except as expressly provided to the contrary in this subchapter, a health insurer offering a qualified health plan in this state shall comply fully with all applicable health insurance laws of this state and regulations adopted and orders issued by the commissioner.~~

SECTION 5. Uncodified Section 3 of Act 1500 of 2013 is repealed.

~~SECTION 3. NOT TO BE CODIFIED. (a)(1) The health insurance marketplace developed through a Federally facilitated Exchange Partnership model shall transfer to the control of the Arkansas Health Insurance Marketplace on July 1, 2015, if the Board of Directors of the Arkansas Health Insurance Marketplace determines that the establishment of a state-based marketplace is approved by the United States Department of Health and Human Services on or before July 1, 2015.~~

~~(2) The board may extend the date of transfer under subdivision (a)(1) of this section.~~

~~(b) The board shall participate in the Federally facilitated Exchange~~

~~Partnership to assist in planning the transition to a state-based health insurance marketplace.~~

SECTION 6. Uncodified Section 4 of Act 1500 of 2013 is repealed.

~~SECTION 4. NOT TO BE CODIFIED. Legislative intent.~~

~~It is the intent of the General Assembly by the enactment of this act to establish a private, nonprofit, health insurance marketplace.~~

SECTION 7. Arkansas Code §§ 20-77-2404 – 20-77-2407, concerning the Health Care Independence Program, are amended to read as follows:

20-77-2404. Definitions.

As used in this subchapter:

(1) “Carrier” means a private entity certified by the State Insurance Department and offering plans ~~through the Arkansas Health Insurance Marketplace;~~

(2) “Cost sharing” means the portion of the cost of a covered medical service that must be paid by or on behalf of eligible individuals, consisting of copayments or coinsurance but not deductibles;

(3) “Eligible individuals” means individuals who:

(A) Are adults between nineteen (19) years of age and sixty-five (65) years of age with an income that is equal to or less than one hundred thirty-eight percent (138%) of the federal poverty level, including without limitation individuals who would not be eligible for Medicaid under laws and rules in effect on January 1, 2013;

(B) Have been authenticated to be United States citizens or documented qualified aliens according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, as existing on January 1, 2013; and

(C) Are not determined to be more effectively covered through the standard Medicaid program, such as an individual who is medically frail or other individuals with exceptional medical needs for whom coverage ~~through the Arkansas Health Insurance Marketplace~~ is determined to be impractical or overly complex, or would undermine continuity or effectiveness of care;

(4) “Healthcare coverage” means healthcare benefits as defined by certification or rules, or both, promulgated by the State Insurance

Department for the Qualified Health Plans or available on the marketplace;

~~(5) “Arkansas Health Insurance Marketplace” means the vehicle created to help individuals, families, and small businesses in Arkansas shop for and select health insurance coverage in a way that permits comparison of available Qualified Health Plans based upon price, benefits, services, and quality, regardless of the governance structure of the marketplace;~~

~~(6) “Independence accounts” means individual financing structures that operate similar to a health savings account or a medical savings account;~~

~~(7)(6) “Premium” means a charge that must be paid as a condition of enrolling in healthcare coverage;~~

~~(8)(7) “Program” means the Health Care Independence Program established by this subchapter; and~~

~~(9)(8) “Qualified Health Plan” means a State Insurance Department-certified individual health insurance plan offered by a carrier through the Arkansas Health Insurance Marketplace.~~

20-77-2405. Administration of Health Care Independence Program.

(a) The Department of Human Services shall:

(1) Create and administer the Health Care Independence Program;
and

(2)(A) Submit and apply for any:

(i) Federal waivers necessary to implement the program in a manner consistent with this subchapter, including without limitation approval for a comprehensive waiver under section 1115 of the Social Security Act, 42 U.S.C. § 1315; and

(ii)(a) Medicaid State Plan Amendments necessary to implement the program in a manner consistent with this subchapter.

(b) The Department of Human Services shall submit only those Medicaid State Plan Amendments under subdivision (a)(2)(A)(ii)(a) of this section that are optional and therefore may be revoked by the state at its discretion.

(B)(i) As part of its actions under subdivision (a)(2)(A) of this section, the Department of Human Services shall confirm that employers shall not be subject to the penalties, including without limitation an assessable payment, under section 1513 of the Patient Protection and

Affordable Care Act, Pub. L. No. 111-148, as existing on January 1, 2013, concerning shared responsibility, for employees who are eligible individuals if the employees:

(a) Are enrolled in the program; and

(b) Enroll in a Qualified Health Plan ~~through the Arkansas Health Insurance Marketplace.~~

(ii) If the Department of Human Services is unable to confirm provisions under subdivision (a)(2)(B)(i) of this section, the program shall not be implemented.

(b)(1) Implementation of the program is conditioned upon the receipt of necessary federal approvals.

(2) If the Department of Human Services does not receive the necessary federal approvals, the program shall not be implemented.

(c) The program shall include premium assistance for eligible individuals to enable their enrollment in a Qualified Health Plan ~~through the Arkansas Health Insurance Marketplace.~~

(d)(1) The Department of Human Services is specifically authorized to pay premiums and supplemental cost-sharing subsidies directly to the Qualified Health Plan for enrolled eligible individuals.

(2) The intent of the payments under subdivision (d)(1) of this section is to increase participation and competition in the Health Insurance Marketplace, intensify price pressures, and reduce costs for both publicly and privately funded health care.

(e) To the extent allowable by law:

(1) The Department of Human Services shall pursue strategies that promote insurance coverage of children in their parents' or caregivers' plan, including children eligible for the ARKids First Program Act, § 20-77-1101 et seq., commonly known as the "ARKids B program";

(2) Upon the receipt of necessary federal approval, during calendar year 2015 the Department of Human Services shall include and transition to the ~~Arkansas Health Insurance Marketplace~~ program:

(A) Children eligible for the ARKids First Program Act, § 20-77-1101 et seq.; and

(B) Populations under Medicaid from zero percent (0%) of the federal poverty level to seventeen percent (17%) of the federal poverty level; and

(3) The Department of Human Services shall develop and implement a strategy to inform Medicaid-recipient populations whose needs would be reduced or better served through participation in the ~~Arkansas Health Insurance Marketplace~~ program.

(f) The program shall include allowable cost sharing for eligible individuals that is comparable to that for individuals in the same income range in the private insurance market and is structured to enhance eligible individuals' investment in their healthcare purchasing decisions.

(g)(1) The State Insurance Department and the Department of Human Services shall administer and promulgate rules to administer the program authorized under this subchapter.

(2) No less than thirty (30) days before the State Insurance Department and the Department of Human Services begin promulgating a rule under this subchapter, the proposed rule shall be presented to the Legislative Council.

(h) The program authorized under this subchapter shall terminate within one hundred twenty (120) days after a reduction in any of the following federal medical assistance percentages:

- (1) One hundred percent (100%) in 2014, 2015, or 2016;
- (2) Ninety-five percent (95%) in 2017;
- (3) Ninety-four percent (94%) in 2018;
- (4) Ninety-three percent (93%) in 2019; and
- (5) Ninety percent (90%) in 2020 or any year after 2020.

(i) An eligible individual enrolled in the program shall affirmatively acknowledge that:

(1) The program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The program is subject to cancellation upon appropriate notice; and

(3) The program is not an entitlement program.

(j)(1) The Department of Human Services shall develop a model and seek from the Centers for Medicare and Medicaid Services all necessary waivers and approvals to allow non-aged, non-disabled program-eligible participants to enroll in a program that will create and utilize independence accounts that operate similarly to a health savings account or medical savings account during the calendar year 2015.

(2) The independence accounts shall:

(A) Allow a participant to purchase cost-effective high-deductible health insurance; and

(B) Promote independence and self-sufficiency.

(3) The state shall implement cost sharing and copays and, as a condition of participation, earnings shall exceed fifty percent (50%) of the federal poverty level.

(4) Participants may receive rewards based on healthy living and self-sufficiency.

(5)(A) At the end of each fiscal year, if there are funds remaining in the account, a majority of the state's contribution will remain in the participant's control as a positive incentive for the responsible use of the healthcare system and personal responsibility of health maintenance.

(B) Uses of the funds may include without limitation rolling the funds into a private sector health savings account for the participant according to rules promulgated by the Department of Human Services.

(6) The Department of Human Services shall promulgate rules to implement this subsection.

(k)(1) State obligations for uncompensated care shall be projected, tracked, and reported to identify potential incremental future decreases.

(2) The Department of Human Services shall recommend appropriate adjustments to the General Assembly.

(3) Adjustments shall be made by the General Assembly as appropriate.

(l) The Department of Human Services shall track the hospital assessment under § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.

(m) On a quarterly basis, the Department of Human Services and the State Insurance Department shall report to the Legislative Council, or to the Joint Budget Committee if the General Assembly is in session, available information regarding:

(1) Program enrollment;

(2) Patient experience;

(3) Economic impact including enrollment distribution;

(4) Carrier competition; and

(5) Avoided uncompensated care.

20-77-2406. Standards of healthcare coverage ~~through Arkansas Health Insurance Marketplace.~~

(a) Healthcare coverage shall be achieved through a qualified health plan at the silver level as provided in 42 U.S.C. §§ 18022 and 18071, as existing on January 1, 2013, that restricts cost sharing to amounts that do not exceed Medicaid cost-sharing limitations.

(b)(1) All participating carriers ~~in the Arkansas Health Insurance Marketplace~~ shall offer healthcare coverage conforming to the requirements of this subchapter.

(2) A participating carrier ~~in the Arkansas Health Insurance Marketplace~~ shall maintain a medical loss ratio of at least eighty percent (80%) for an individual and small group market policy and at least eighty-five percent (85%) for a large group market policy as required under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as existing on January 1, 2013.

(c) To assure price competitive choice among healthcare coverage options, the State Insurance Department shall assure that at least two (2) qualified health plans are offered in each county in the state.

(d) Health insurance carriers offering healthcare coverage for program-eligible individuals shall participate in the Health Care Payment Improvement Initiative including:

- (1) Assignment of primary care clinician;
- (2) Support for patient-centered medical home; and
- (3) Access of clinical performance data for providers.

(e) On or before July 1, 2013, the State Insurance Department shall implement through certification requirements or rules, or both, the applicable provisions of this subchapter.

20-77-2407. Enrollment.

(a) The General Assembly shall assure that a mechanism ~~within the Arkansas Health Insurance Marketplace~~ is established and operated to facilitate enrollment of eligible individuals.

(b) The enrollment mechanism shall include an automatic verification system to guard against waste, fraud, and abuse in ~~the program~~ Health Care

Independence Program.