

1 State of Arkansas
2 95th General Assembly
3 Regular Session, 2025
4

As Engrossed: H4/8/25

A Bill

HOUSE BILL 1295

5 By: Representative L. Johnson
6 By: Senator Irvin
7

For An Act To Be Entitled

8
9 AN ACT TO CREATE THE HEALTHCARE COST-SHARING
10 COLLECTIONS TRANSPARENCY ACT; AND FOR OTHER PURPOSES.
11

Subtitle

12
13 TO CREATE THE HEALTHCARE COST-SHARING
14 COLLECTIONS TRANSPARENCY ACT.
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16

17 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
18

19 SECTION 1. Arkansas Code Title 23, Chapter 99, is amended to add an
20 additional subchapter to read as follows:
21

22 Subchapter 19 – Healthcare Cost-Sharing Collections Transparency Act
23

24 23-99-1901. Title.

25 This subchapter shall be known and may be cited as the "Healthcare
26 Cost-Sharing Collections Transparency Act".
27

28 23-99-1902. Definitions.

29 As used in this subchapter:

30 (1)(A) "Contracting entity" means a healthcare insurer, or a
31 subcontractor, affiliate, or other entity that contracts directly or
32 indirectly with a healthcare provider for the delivery of healthcare services
33 to enrollees.

34 (B) "Contracting entity" includes without limitation:

35 (i) An insurance company;

36 (ii) A health maintenance organization;



1 (iii) A hospital and medical service corporation;
2 (iv) A preferred provider organization;
3 (v) A risk-based provider organization;
4 (vi) A third-party administrator;
5 (vii) A nonprofit agricultural membership
6 organization; and

7 (viii) A prescription benefit management company;
8 (2)(A) "Cost sharing" means the amount of the costs that are
9 covered by a health benefit plan for which an enrollee is financially
10 responsible.

11 (B) "Cost sharing" includes without limitation a
12 deductible payment, a coinsurance amount, a copayment, or other similar
13 charges.

14 (C) "Cost sharing" does not include a premium, balance
15 billing amount for out-of-network healthcare providers, or the cost of
16 noncovered services;

17 (3) "Enrollee" means an individual who is entitled to receive
18 healthcare services under the terms of a health benefit plan;

19 (4) "Entity of the state" means an agency, board, bureau,
20 commission, committee, council, department, division, institution of higher
21 education, office, public school, quasi-public organization, or other
22 political subdivision of the state;

23 (5)(A) "Health benefit plan" means an individual, blanket, or
24 group plan, policy, or contract for healthcare services issued, renewed, or
25 extended in this state by a healthcare insurer.

26 (B) "Health benefit plan" includes a nonfederal
27 governmental plan as defined in 29 U.S.C. § 1002(32), as it existed on
28 January 1, 2025.

29 (C) "Health benefit plan" does not include:
30 (i) A plan that provides only dental benefits;
31 (ii) A plan that provides only eye and vision
32 benefits;

33 (iii) A disability income plan;
34 (iv) A credit insurance plan;
35 (v) Insurance coverage issued as a supplement to
36 liability insurance;

1 (vi) Medical payments under an automobile or
2 homeowners' insurance plan;

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

6 (viii) A plan that provides only indemnity for
7 hospital confinement;

8 (ix) An accident-only plan;

9 (x) A specified disease plan;

10 (xi) A policy, contract, certificate, or agreement
11 offered or issued by a healthcare insurer to provide, deliver, arrange for,
12 pay for, or reimburse any of the costs of healthcare services, including
13 pharmacy benefits, to an entity of the state;

14 (xii) A long-term care insurance plan; or

15 (xiii) A healthcare provider self-insured plan;

16 (6) "Healthcare contract" means a contract entered into,
17 materially amended, or renewed between a contracting entity and a healthcare
18 provider for the delivery of healthcare services to an enrollee;

19 (7)(A) "Healthcare insurer" means an entity that is authorized
20 by this state to offer or provide health benefit plans, policies, subscriber
21 contracts, or any other contracts of a similar nature that indemnify or
22 compensate a healthcare provider for the provision of healthcare services.

23 (B) "Healthcare insurer" includes:

24 (i) An insurance company;

25 (ii) A hospital and medical service corporation;

26 (iii) A health maintenance organization;

27 (iv) A risk-based provider organization;

28 (v) A nonprofit agricultural membership
29 organization;

30 (vi) Any sponsor of a nonfederal self-funded
31 governmental plan in this state; and

32 (vii) A third-party administrator or other entity
33 providing claims administration services for a health benefit plan;

34 (8) "Healthcare provider" means a person or entity that is
35 licensed, certified, or otherwise authorized by the laws of this state to
36 administer healthcare services;

1 (9) "Healthcare services" means services or goods provided for
2 the purpose of or incidental to the purpose of preventing, diagnosing,
3 treating, alleviating, relieving, curing, or healing human illness, disease,
4 condition, disability, or injury;

5 (10) "Medical loss ratio" means the measure used in healthcare
6 insurance to assess the percentage of premium dollars spent on medical claims
7 and quality improvements versus administrative costs;

8 (11) "Net premium income" means the dollar amount of direct
9 business plus reinsurance assumed minus reinsurance ceded; and

10 (12) "Premium" means the dollar amount charged for the insurance
11 coverage of an enrollee.

12
13 23-99-1903. Transparency and reporting.

14 (a)(1)(A) Annually on or before March 1, a healthcare insurer shall
15 file with the Insurance Commissioner a full and true statement of the
16 healthcare insurer's financial condition, transactions, and affairs as of the
17 December 31 preceding.

18 (B)(i) The commissioner may grant an extension of time to
19 file the statement required under subdivision (a)(1)(A) of this section for
20 good cause shown.

21 (ii) The commissioner may grant an extension of time
22 for good cause under subdivision (a)(1)(B)(i) of this section only if a
23 written application for an extension of time is received at least five (5)
24 business days before the filing due date.

25 (2) The statement required under subdivision (a)(1)(A) of this
26 section shall be prepared according to the companion National Association of
27 Insurance Commissioners' Annual and Quarterly Statement Instructions, as
28 adopted by rule by the commissioner, and follow those accounting principles
29 and procedures prescribed by the companion National Association of Insurance
30 Commissioners' Accounting Practices and Procedures Manual, as adopted by rule
31 by the commissioner.

32 (3) The statement required under subdivision (a)(1)(A) of this
33 section shall include the healthcare insurer's:

34 (A) Total assets;

35 (B) Total liabilities;

36 (C) Total reserves;

1 (D)(i) Net premium income for each line of business of the
2 healthcare insurer.

3 (ii) Each line of business of the healthcare insurer
4 shall include:

5 (a) Comprehensive hospital plans and
6 comprehensive medical plans;

7 (b) Medicare supplement plans;

8 (c) Dental-only plans;

9 (d) Vision-only plans;

10 (e) The Federal Employees Health Benefits
11 Program;

12 (f) Medicare;

13 (g) Medicare Advantage Plans;

14 (h) The Arkansas Medicaid Program;

15 (i) Plans offered under the Medicaid Provider-
16 Led Organized Care Act, § 20-77-2701 et seq., or any successor program;

17 (j) Qualified health plans offered under the
18 Arkansas Health and Opportunity for Me Program or any successor program;

19 (k) Other Medicaid plans; and

20 (l) Other health benefit plans;

21 (E)(i) Total claims paid for each line of business of the
22 healthcare insurer.

23 (ii) Each line of business of the healthcare insurer
24 shall include:

25 (a) Comprehensive hospital plans and
26 comprehensive medical plans;

27 (b) Medicare supplement plans;

28 (c) Dental-only plans;

29 (d) Vision-only plans;

30 (e) The Federal Employees Health Benefits
31 Program;

32 (f) Medicare;

33 (g) Medicare Advantage Plans;

34 (h) The Arkansas Medicaid Program;

35 (i) Plans offered under the Medicaid Provider-
36 Led Organized Care Act, § 20-77-2701 et seq., or any successor program;

1 (j) Qualified health plans offered under the
2 Arkansas Health and Opportunity for Me Program or any successor program;

3 (k) Other Medicaid plans; and

4 (l) Other health benefit plans;

5 (F)(i) Total claims denied for each line of business of
6 the healthcare insurer.

7 (ii) Each line of business of the healthcare insurer
8 shall include:

9 (a) Comprehensive hospital plans and
10 comprehensive medical plans;

11 (b) Medicare supplement plans;

12 (c) Dental-only plans;

13 (d) Vision-only plans;

14 (e) The Federal Employees Health Benefits

15 Program;

16 (f) Medicare;

17 (g) Medicare Advantage Plans;

18 (h) The Arkansas Medicaid Program;

19 (i) Plans offered under the Medicaid Provider-
20 Led Organized Care Act, § 20-77-2701 et seq., or any successor program;

21 (j) Qualified health plans offered under the
22 Arkansas Health and Opportunity for Me Program or any successor program;

23 (k) Other Medicaid plans; and

24 (l) Other health benefit plans; and

25 (G) Low, high, and average premium price data for each
26 line of service of the healthcare insurer.

27 (b) A healthcare insurer shall file an executive summary of the
28 statement required under subdivision (a)(1)(A) of this section with the:

29 (1) House Committee on Insurance and Commerce; and

30 (2) Senate Committee on Insurance and Commerce.

31 (c)(1) Annually, between thirty (30) and sixty (60) days before the
32 initial date of open enrollment for Medicare, a healthcare insurer shall send
33 a report to each enrollee.

34 (2) The report required under subdivision (c)(1) of this section
35 shall include:

36 (A) The dollar amount of premiums collected from the

1 enrollee and paid to the healthcare insurer from the previous period of
2 January 1 through December 31;

3 (B) The dollar amount of premiums paid to the healthcare
4 insurer by a person or entity, including without limitation an employer,
5 other than the enrollee on behalf of the enrollee from the previous period of
6 January 1 through December 31;

7 (C) The dollar amount of cost sharing expected to be
8 collected by the healthcare provider, itemized by deductibles, coinsurance,
9 and copayments, or similar charges from the enrollee from the previous period
10 of January 1 through December 31;

11 (D) The payment made to each in-network healthcare
12 provider on behalf of the enrollee from the previous period of January 1
13 through December 31;

14 (E) The payment made to each out-of-network healthcare
15 provider on behalf of the enrollee from the previous period of January 1
16 through December 31;

17 (F) A list of claims denied to a healthcare provider who
18 provided healthcare services to the enrollee from the previous period of
19 January 1 through December 31;

20 (G) The low, average, and high premium rates comparable to
21 the enrollee's health benefit plan;

22 (H) A list of any underwriting, auditing, actuarial,
23 financial analysis, treasury, and investment expenses;

24 (I) A list of any marketing and sales expenses, including
25 without limitation advertising, member relations, member enrollment, and all
26 expenses associated with producers, brokers, and benefit consultants;

27 (J) A list of any claims operations expenses, including
28 without limitation those expenses for adjudication, appeals, settlements, and
29 expenses associated with paying claims;

30 (K) A list of any medical administration expenses,
31 including without limitation disease management, utilization review, and
32 medical management;

33 (L) A list of any network operations expenses, including
34 without limitation those expenses for contracting, hospital and physician
35 relations, and medical policy procedures;

36 (M) A list of any charitable expenses, including without

1 limitation to contributions to tax-exempt foundations and community benefits;
 2 (N) The amount of state insurance premium taxes;
 3 (O) The amount paid for board, bureau, and association
 4 fees;
 5 (P) The fees related to depreciation; and
 6 (Q) A list of miscellaneous expenses described in detail
 7 by expense, including any expense not included in subdivisions (c)(2)(H)-(P)
 8 of this section.

9
 10 23-99-1904. Prohibition on pricing increases.

11 (a) Before a healthcare insurer's implementation of an increase in
 12 premium rates, cost sharing, or per-member-per-month costs or payments for
 13 rates or insurance policies that are required to be reviewed by the Insurance
 14 Commissioner under §§ 23-79-109 and 23-79-110, the commissioner shall
 15 consider the following additional factors in his or her review:

16 (1) The extent to which the healthcare insurer's RBC level as
 17 defined in § 23-63-1302 is less than six hundred fifty percent (650%); and

18 (2)(A) To the extent permitted by federal law, whether the
 19 healthcare insurer's medical loss ratio is greater than eighty-five percent
 20 (85%) on clinical services and quality improvement.

21 (B) The calculation of medical claims and quality
 22 improvements for a healthcare insurer's medical loss ratio under subdivision
 23 (a)(2)(A) of this section shall exclude:

24 (i) Any performance-based compensation, bonus, or
 25 other financial incentive paid directly or indirectly to a contracting entity
 26 employee, affiliate, contractor, or other entity or individual;

27 (ii) Any expense under § 23-99-1903(c)(2)(H)-(Q);

28 (iii) Any expense associated with carrying enrollee
 29 medical debt; and

30 (iv) Cost sharing.

31 (b) A healthcare insurer in the fully insured group market shall
 32 consider the factors in subsection (a) of this section before implementing an
 33 increased premium rate, cost sharing, or enrollee per-member-per-month fee.

34
 35 23-99-1905. Violation of Trade Practices Act – Enforcement.

36 (a) A violation of this subchapter is a deceptive act, as defined by

1 the Trade Practices Act, § 23-66-201 et seq., and § 4-88-101 et seq.

2 (b) All remedies, penalties, and authority granted to the Insurance
3 Commissioner under the Trade Practices Act, § 23-66-201 et seq., shall be
4 available to the commissioner for the enforcement of this subchapter.

5 (c) The State Insurance Department shall enforce this subchapter.

6
7 23-99-1906. Rules.

8 The Insurance Commissioner may promulgate rules to implement this subchapter.

9
10 23-99-1907. Severability.

11 The provisions of this section shall be severable, and if any phrase,
12 clause, sentence, or provision is deemed unenforceable, the remaining
13 provisions of the section shall be enforceable.

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15 */s/L. Johnson*
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