State of Arkansas *As Engrossed: H4/8/25 H4/10/25*
95th General Assembly **A Bill**
Regular Session, 2025 HOUSE BILL 1295

By: Representative L. Johnson
By: Senator Irvin

For An Act To Be Entitled

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

Subtitle

TO CREATE THE HEALTHCARE COST-SHARING COLLECTIONS TRANSPARENCY ACT.

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

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

Subchapter 19 — Healthcare Cost-Sharing *Collections Transparency Act*

23-99-1901. Title.

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

23-99-1902. Definitions.

As used in this subchapter:

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

(B) "Contracting entity" includes without limitation:

(i) An insurance company;

(ii) A health maintenance organization;

(iii) A hospital and medical service corporation;

(iv) A preferred provider organization;

(v) A risk-based provider organization;

(vi) A third-party administrator;

(vii) A nonprofit agricultural membership organization; and

(viii) A prescription benefit management company;

(2)(A) "Cost sharing" means the amount of the costs that are covered by a health benefit plan for which an enrollee is financially responsible.

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

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

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

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

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

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

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

(i) A plan that provides only dental benefits;

(ii) A plan that provides only eye and vision benefits;

(iii) A disability income plan;

(iv) A credit insurance plan;

(v) Insurance coverage issued as a supplement to liability insurance;

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

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

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

(ix) An accident-only plan;

(x) A specified disease plan;

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

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

(xiii) A healthcare provider self-insured plan;

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

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

(B) "Healthcare insurer" includes:

(i) An insurance company;

(ii) A hospital and medical service corporation;

(iii) A health maintenance organization;

(iv) A risk-based provider *organization; and*

(v) A nonprofit agricultural membership *organization.*

(C) "Healthcare insurer" does not include:

(i) Any sponsor of a nonfederal self-funded governmental plan in this state; or

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

(8) "Healthcare provider" means a person or entity that is licensed, certified, or otherwise authorized by the laws of this state to

administer healthcare services;

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

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

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

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

23-99-1903. Transparency and reporting.

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

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

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

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

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

(A) Total assets;

(B) Total liabilities;

(C) Total reserves;

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

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

(a) Comprehensive hospital plans and comprehensive medical plans;

(b) Medicare supplement plans;

(c) Dental-only plans;

(d) Vision-only plans;

(e) The Federal Employees Health Benefits Program;

(f) Medicare;

(g) Medicare Advantage Plans;

(h) The Arkansas Medicaid Program;

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

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

(k) Other Medicaid plans; and

(l) Other health benefit plans;

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

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

(a) Comprehensive hospital plans and comprehensive medical plans;

(b) Medicare supplement plans;

(c) Dental-only plans;

(d) Vision-only plans;

(e) The Federal Employees Health Benefits Program;

(f) Medicare;

(g) Medicare Advantage Plans;

(h) The Arkansas Medicaid Program;

(i) Plans offered under the Medicaid Provider-

Led Organized Care Act, § 20-77-2701 et seq., or any successor program;

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

(k) Other Medicaid plans; and

(l) Other health benefit plans;

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

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

(a) Comprehensive hospital plans and comprehensive medical plans;

(b) Medicare supplement plans;

(c) Dental-only plans;

(d) Vision-only plans;

(e) The Federal Employees Health Benefits Program;

(f) Medicare;

(g) Medicare Advantage Plans;

(h) The Arkansas Medicaid Program;

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

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

(k) Other Medicaid plans; and

(l) Other health benefit plans; and

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

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

(1) House Committee on Insurance and Commerce; and

(2) Senate Committee on Insurance and Commerce.

(c)(1) Annually, between thirty (30) and sixty (60) days before the *initial date of open enrollment for Medicare, a healthcare insurer shall make a report available to each enrollee either by mail or other electronic means.*

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

(A) The dollar amount of premiums collected from the enrollee and paid to the healthcare insurer from the previous period of January 1 through December 31;

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

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

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

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

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

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

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

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

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

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

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

(M) A list of any charitable expenses, including without limitation to contributions to tax-exempt foundations and community benefits;

(N) The amount of state insurance premium taxes;

(O) The amount paid for board, bureau, and association fees;

(P) The fees related to depreciation; and

(Q) A list of miscellaneous expenses described in detail by expense, including any expense not included in *subdivisions (c)(2)(H)–(P)* of this section.

23-99-1904. Prohibition on pricing increases.

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

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

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

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

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

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

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

(iv) Cost sharing.

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

23-99-1905. Violation of Trade Practices Act — Enforcement.

(a) A violation of this subchapter is a deceptive act, as defined by the Trade Practices Act, § 23-66-201 et seq., and § 4-88-101 et seq.

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

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

23-99-1906. Rules.

The Insurance Commissioner may promulgate rules to implement this subchapter.

23-99-1907. Severability.

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

/s/L. Johnson