Center for Consumer Information and Insurance Oversight
State Planning and Establishment Grants for the
Affordable Care Act's (ACA) Exchanges

Quarterly Project Report

Date: April 15, 2011

State: Arkansas

Project Title: Arkansas Health Insurance Exchange Planning

Project Quarter Reporting Period: Quarter 2 (1/1/2011 – 3/31/2011)

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Award number: 1 HBEIE100001-01-00

Date submitted: 2/15/2011

Project Summary

Overview. Second quarter Arkansas Health Benefits Exchange planning activities included:

- Continued interagency planning and education efforts;
- Expanding network of stakeholders engaged in developing Arkansas's Health Benefits Exchange;
- Seeking legislative authority for Arkansas's Health Benefits Exchange;
- Developing and advertising a consolidated *Health Benefits Exchange Background Research* Request for Proposal (RFP); and
- Finalizing plans with University of Arkansas for Medical Sciences (UAMS) Partners for Inclusive Communities for Stakeholder research.

Bruce Donaldson, CHC, an experienced health insurance professional with 25 years of industry experience, was hired as project planning specialist. Also during the reporting period, the Arkansas Health Benefits Exchange project moved into newly renovated office space at Arkansas Insurance Department.

The federal financial report (SF 425) is included as Attachment 1.

Core Areas

Background Research

We elected to release one consolidated RFP for broad *Exchange Planning Background Research* through the Arkansas Office of State Procurement. The scope of work was defined and a scoring template established. The RFP was advertised through the Arkansas Office of State Procurement and also placed on the Arkansas Insurance Department Exchange Planning website. An RFP review team has been established that includes reviewers internal and external to the Arkansas Insurance Department. The full RFP and addendums may be viewed at www.insurance.arkansas.gov/hied/divpage.htm.

Background Research proposals are due April 15, 2011 and the vendor selection process will be complete before the end of April. Following the required Arkansas legislative review process, we expect to have the selected vendor approved and a subaward contract in place by the end of May, with work to begin no later than June 1, 2011. The contractor will have 90 days to perform the background research. A report and recommendations will be due by September 1, 2011.

Stakeholder Involvement/Consultation

The Arkansas Health Benefits Exchange planning project seeks genuine, on-going stakeholder involvement. During the past quarter, strategies for stakeholder involvement have included:

1) Finalizing plans for key informant interviews, community meetings, stakeholder summit involvement, and reporting/recommendations to be conducted by University of Arkansas for Medical Sciences (UAMS) Partners for Inclusive Communities (Partners) and UAMS College of Public Health (COPH). *Exchange Planning staff and Arkansas Insurance Commissioner Jay Bradford have met with skilled and experienced Stakeholder Involvement leaders David Deere, MSW, MTh, Director of UAMS Partners, and John Wayne, PhD, Director of Policy and Management at UAMS COPH. The formal Intergovernmental Agreement for Stakeholder Involvement work between Arkansas Insurance Department and UAMS Partners has been drafted and agreed to by each party; final execution of the agreement is in process (See attachment 2). A revised timeframe directs key informant interviews to be completed in May, Community Meetings completed in June, and a preliminary Stakeholder Input report due by July 1, 2011. The Scope of Work for Stakeholder Involvement also includes participation in a Stakeholder Summit (likely October, 2011) and creation of a recommendations report by November, 2011. Public Hearings to discuss stakeholder recommendations will follow, likely in November/December 2011.*

2) Establishing Stakeholder Workgroups. *Participants for five Exchange Planning Stakeholder Workgroups have been identified and recruited. We are very pleased with the expressed interest and commitment of more than 80 diverse stakeholders. Each workgroup is comprised of 12 -20 committed individuals. The workgroups are: State Agencies; Consumers; Providers; Outreach and Education; and Community Leaders. We expect these workgroups to address similar questions/issues, but from diverse perspectives. Workgroup members include insurance carrier presidents, local insurance producers, elected officials including*

state legislators (and an immediate past U.S. Congressman), agency directors, large and small business owners and human resource managers, uninsured adults, students and persons recovering from substance addiction, Governor's office staff, health care providers including hospitals, philanthropic organizations, labor organizations, and advocates for children, families, elderly, poor, and minority groups including those with English as a second language. Arkansas Health Benefits Exchange Planning staff will support the work of these workgroups. Each workgroup will launch in early April. Commissioner Bradford will present the "charge and opportunity" to each group.

A sixth Exchange Planning workgroup on specific Health Benefits Exchange Information Technology will be launched in the next quarter with shared leadership by the State's Exchange Planning, Health Information Technology, and State Information Systems directors. Each of these key leaders has committed to this planning which will include a gap analysis, and interagency design and implementation efforts driven by shared, non-duplicative, integrated, and efficient strategies to effect the best possible Arkansas Health Benefits Exchange—one that successfully integrates with broader health systems improvement technology planning. This IT workgroup will include industry experts.

3) The selected vendor for Background Research, Stakeholder Inclusion Research contractor, and the six Exchange Planning Workgroups will each have on-going communication with the others throughout the Exchange Planning process. *We expect findings from each group to inform the others—as our plan is to ensure broad, diverse, and genuine stakeholder inclusion in planning Arkansas's Exchange. This inter-group communication expectation has been made explicit to each planning group via contract language or orientation materials. Additionally, materials produced by each group will be posted on the AID Health Benefits Exchange Web-Site.*

4) On-going dialogue with previously and newly identified stakeholders. We continue to respond to multiple requests for information, meetings, and presentations and have met with diverse state and private stakeholders over the past quarter. Responses have included updates to state legislators on the Exchange Planning processes and timeline. *Other stakeholders have included the self-chartered Industry Health Care Reform Education and Advisory Committee, Arkansas Advocates for Children and Families, AARP-Arkansas, Arkansas Center for Health Improvement, Arkansas Christian Scientists, Arkansas Employee Benefits Division, Arkansas Health Information Exchange Advisory Council, Arkansas Health-Related State Agency Directors, Arkansas Hospital Association, Arkansas Nurses Association, Community Mental Health Centers of Arkansas, Delta Dental, United Food and Commercial Workers Union, and numerous (often repeat) private vendors interested in later Exchange work in Arkansas (Aon/Hewett, Choice Administrators, BenefitFocus, Connecture, Maximus, Fox-Cognosante, Get Insured, HealthSource, Oracle, and Xerox/ACS).*

Program Integration

Progress continues with interagency planning for a single, integrated eligibility/enrollment portal that will provide a "no wrong door" entry to the Arkansas Benefits Exchange where consumers can *shop* for quality, affordable health coverage, *choose* a product that best meets their needs, and *enroll* with any subsidies for which they are eligible applied to their premium. Interest in

also achieving integrated eligibility determinations and enrollment into related public services such as SNAP, TANF, Low Income Child Care Vouchers, etc. continues.
During the past quarter, interagency work through weekly meetings led by the State Department of Information Systems established a timeline and Request for Qualifications for a vendor to establish a Single Sign-On Authentication Solution that will meet needs of multiple stakeholders including the Health Benefits Exchange, State Health Information Exchange, Medicaid, providers, issuers, and others. Key agency representatives have agreed to a single sign-on strategy and a draft procurement document is expected to be finalized in April and signed by directors of Medicaid, Health Information Technology, Department of Information Services and Health Benefits Exchange Planning. System development and maintenance costs are to be charged to user agencies in a method to be determined and based on usage. *It is expected that Arkansas's Health Information Exchange (SHARE) will serve as secure, virtual warehouse for data including a master person index, master record, and possibly an insurance all-claims data base.*

Exchange Planning staff met with the Executive Director and Chief Operating Officer of the Arkansas Employee Benefits Division (EBD), the state entity that serves as administrator for State Employee and Teacher Health Benefit Plans. This Division (a part of the Arkansas Department of Finance and Administration) is expected to have knowledge, skills, technology and lessons learned that will be helpful to the developing Exchange.

During the past quarter, Arkansas Governor Mike Beebe submitted a waiver request to DHHS Secretary Sebelius for Arkansas to develop a bold, innovative Medicaid-Medicare-Private Insurance health payment reform plan based on bundled payments for episodes of evidence-based care using a health care home model. An initial DHHS answer is expected by May 1, 2011, following which we will determine how such a plan if adopted would affect the developing Arkansas Health Benefits Exchange.

Resources & Capabilities
Bruce Donaldson was hired as Exchange Planning Project Specialist in mid-February. He has more than 20 years health insurance experience through successful employment relationships with carriers, brokers, and producers. Mr. Donaldson combines critical insurance industry expertise with strong customer service skills that will effectively complement the project director's experience with strategic planning, change, and collaborative program development in health care. Together, they make a strong leadership team for planning the Arkansas Health Benefits Exchange.

Due to the workload and coordination needs generated through multiple research and stakeholder involvement activities, the project is planning to hire a part-time employee for administrative support services. Because there is no state approved position for administrative support for the Exchange Planning effort, a temporary employment service will be used to staff this need until such time as federal and state approval is obtained for the addition of an administrative support position.

The Arkansas Center for Health Improvement (ACHI) Director (Arkansas's Surgeon General Joe Thompson) recently designated David Boling, J.D, as liaison to Arkansas Health Benefits

Exchange planning and dedicated a significant portion of this time to work on this effort. He has begun preliminary research into the likely effect of the Affordable Care Act (and Health Benefits Exchanges in particular) on business owners' choosing to continue, drop, or add insurance coverage as an employee benefit. He is also studying the benefits of tobacco use cessation services as a required essential benefit for Arkansas Health Plans. The ACHI also requested technical assistance funding from the Robert Wood Johnson Foundation to augment Health Exchange Planning efforts in Arkansas; however, this request was not funded.

Arkansas Department of Information Systems Director Claire Bailey and Arkansas Health Information Technology Director Ray Scott have engaged with the AID's Exchange Planning efforts with a commitment to efficiency, coordination, and non-duplication as we develop shared strategies for health information system planning, implementation, and sustainability. We have met several times to better understand the State's technology infrastructure and needs. We have agreed that representatives of all three agencies will meet with potential vendors in an effort to coordinate and demonstrate that coordination to potential vendors.

Background research, consultation with other states, and interagency collaboration is expected to help determine the needs, costs, and financing options for a quality, sustainable Exchange for Arkansans. Even though Governor Mike Beebe directed that no state general revenue is to be used for Health Benefits Exchange planning, implementation or continuing operations, several Arkansas legislators expressed concern about federal funds being spent for Exchange planning and requested and received an accounting of Health Benefits Exchange Planning activities and finances (See also Regulatory and Policy Actions below). Further, a letter was received from Joel Ario indicating that Federal funds awarded to the State would not need to be repaid in the event that ACA is overturned.

Internally, within the Arkansas Insurance Department, leadership of the three CCIIO-funded projects (Health Benefits Exchange, Premium Rate Review, and Consumer Assistance Program) have begun to meet monthly for strategic sharing and planning. The Premium Rate Review and Exchange Planning Programs have moved into newly renovated connecting space which allows for greater on-going communication and sharing of information between these programs. We note that the need for understandable consumer information, consumer outreach education, and consumer empowerment is shared and advocated by all three programs.

Governance

Arkansas HB 2138 (Attachment 3) proposed establishment of the Arkansas Health Benefits Exchange as a "non-profit legal entity…the purpose of which will be to increase the access to quality and affordable health care coverage, reduce the number of uninsured persons in Arkansas, and increase availability and consumer choice of health care coverage through the exchange to qualified individuals and small employers". The bill outlined composition of the Arkansas Benefits Exchange board that would be appointed by the Arkansas Insurance Commissioner. The Insurance Commissioner was also provided authority to promulgate rules to implement Arkansas's Exchange in compliance with DHHS regulations. Following approximately ten amendments to address concerns of Republican legislators and the insurance industry in Arkansas, HB 2138 failed to pass during Arkansas's 88th General Assembly (see

Regulatory and Policy Actions below) and was referred to Interim Study by the Joint Insurance and Commerce Committee.

Finance

Background research and stakeholder recommendations will assist Arkansas in designing and implementing effective and transparent financial management strategies to establish and sustain the Arkansas Health Benefits Exchange. These financial plans will address prevention and reporting of fraud, waste, and abuse. They will require annual public reports that are easily accessible and understandable. No specific Exchange financial management plans were developed during this reporting period

Technical Infrastructure

Key Arkansas agencies (Department of Human Services, Insurance Department, Health Department, Information Services, and Health Information Technology) continue to collaboratively work on shared infrastructure needs and timelines for Arkansas's multiple health systems technology improvement needs. Arkansas's Medicaid Management Information System (MMIS) has a current RFP for improvements, and our Health Information Technology (SHARE) system will be releasing an implementation RFP in the near future. Arkansas Department of Information Systems is assisting each entity to help ensure efficient, collaborative, non-duplicative, integrated, and secure systems for information and rules sharing among these key agencies.

Arkansas's Exchange Planning Background Research RFP requires a gap analysis of technical infrastructure needs for Exchange information technology (IT) in anticipation of a later Exchange IT implementation RFP. Language in the Exchange Planning RFP was reviewed by the above named agency partners for improvement suggestions and to ensure coordination in planning.

Planners and managers from the Arkansas Department of Information Systems (DIS), Health Information Technology (HIT), and Arkansas Insurance Department/Health Benefits Exchange have agreed to meet together with potential vendors of technical solutions in order to assess these solutions from our differing perspectives *and* to reinforce our commitment to collaboration and efficiency. This is working well, as evidenced by vendors now asking to meet jointly with representatives of the key agencies.

We met with Connect Arkansas CEO Sam Walls to learn about broadband access and internet connectivity across Arkansas. Only 24% of Arkansans subscribed to an internet service within the past year. Further, we suspect a very low percentage of low income Arkansans have user knowledge (or convenient internet access) for direct web-based health benefits enrollment. We also suspect that the percentage of Arkansans using social media tools is much lower than across the nation, but higher among those in the under 33 year old age group. We will study internet mapping and social media connectivity to help inform methods of consumer outreach, education, and enrollment services likely to reach most Arkansans and assist them in enrolling in a plan of their choice that best meets their individual needs.

We are committed to ensure that program decisions lead technical infrastructure decisions rather than vice versa. It is expected that Exchange Planning Workgroups will begin to recommend service processes that will drive information technology needs (e.g., integrated, continuous enrollment in benefits plans that work for families; continuity of provider networks; congruity among eligibility processes between Medicaid, CHIP, and private plans, transparency, etc.) Arkansas looks forward to following early innovator grantees in their work to design efficient, effective solutions to Exchange implementation that interface with other health system improvement technologies.

Business Operations

Decisions/activities regarding Exchange Business Operations will follow study of Background and Stakeholder Research findings and recommendations, as well as recommendations by Exchange Planning Workgroups. There has been no progress in this core area during the first two reporting periods.

Regulatory or Policy Actions

The 88th Arkansas General Assembly provided multiple challenges to early efforts to achieve legal authority for development of the Arkansas Health Benefits Exchange. (Also see Governance above.) A number of Republican legislators were elected on a platform that included repealing provisions of the Affordable Care Act in Arkansas, and this vocal minority was effective in slowing expected Exchange development progress during the 2011 legislative session.

- Early in the Session, House Bill 709 (see Attachment 4) to require state agencies to report all expenditures related to the Affordable Care Act and to *not* implement any ACA provisions without legislative authority failed. (See also Attachment 6 for media clips).

- HB 1053 (see attachment 5) to repeal the mandatory health coverage enrollment provision of the Affordable Care Act also failed to pass out of the House Public Health Committee (see attachment 6 for media clips).

- SB113 (see attachment 7) to prohibit abortion coverage (except in cases where a mother's life was in danger) by any health insurance plan obtained through the Arkansas Health Benefits Exchange also failed to pass (see also attachment 6 for media clips).

- A first attempt to authorize and establish governance of the Arkansas Health Benefits Exchange, House Bill 2138 (see attachments 3 and 6) of 2011, failed to pass the 88th Arkansas General Assembly. House Insurance and Commerce Committee Chairman Fred Allen (D) was bill sponsor. Following more than ten amendments negotiated with insurance industry and Republican Party representatives to advance the legislation, the initial vote in the House Insurance and Commerce Committee was 10 "for" to 7 "against" (11 votes were needed for passage) along party lines. The bill received a "Do Pass" vote (11-7) in the House Insurance and Commerce Committee on the following day. Republican opposition centered around a desire to "stop or slow down" the exchange planning process in order to allow time to determine whether the Affordable Care Act would be "struck down" by the U.S. Supreme Court. The central message of bill supporters was that an Arkansas Benefits Exchange run

by Arkansans for Arkansans would be preferable to a Health Insurance Exchange in Arkansas operated by the Federal Government. The Insurance Department, Arkansas Hospital Association, AARP-Arkansas, Independent Insurance Agents Association of Arkansas, Arkansas Surgeon General, Arkansas Foundation for Medical Care, and Arkansas Advocates for Children and Families all testified for the exchange enabling legislation bill. Arkansas Blue Cross and Blue Shield also supported the bill. Opponents were Republicans voting as a block. HB 2138 never came to a vote by the full House or Senate. The Bill was eventually referred to Interim Study in the Joint Insurance and Commerce Committee.

- In the final days of the 2011 Arkansas General Assembly, HB 2116—the Arkansas Insurance Department's Appropriation Bill—was blocked three times from receiving the required 75% vote before finally being approved on a fourth attempt. The controversy rested squarely on authorization to spend the $1 million CCIIO Exchange Planning Grant funds. Opponents wanted exchange planning halted. Removing State authority for spending the federal planning dollars would have accomplished such. The threat to shut down the entire Arkansas Insurance Department (AID) over this issue was not effective. Commissioner Jay Bradford, backed by Arkansas Governor Mike Beebe, refused to remove the planning grant spending appropriation from the Insurance Department appropriation bill. In the end, the Insurance Department prevailed and the AID budget appropriation *containing the CCIIO planning funds* passed (See Attachment 6- Media Clips).

While we are concerned about the timing hurdles this legislative session imposed on our planning process, we remain committed to planning the best possible Health Benefits Exchange for Arkansans. Our thoughtful, non-partisan planning activities are continuing. Legislators from each party have been invited and agreed to serve on the AID's Exchange Planning Workgroups. In addition, legislators will be encouraged to attend community stakeholder meetings discussing development of the Arkansas Benefits Exchange in their respective areas. Key informant interviews will seek a better understanding of issues dividing stakeholders. Exchange Planning Staff and the Insurance Commissioner will actively engage with the public, including the Joint Interim Legislative Committee studying this issue, to provide needed data and information. A broad-based public information campaign is needed.

Barriers, Lessons Learned, and Recommendations to the Program

Barriers to widespread support for the Arkansas Benefits Exchange include a lack of understanding by the people of Arkansas about benefits *for them* of the Affordable Care Act in general and the Health Benefits Exchange in particular. We learned that rational discussion of facts is improbable at best in the heat of emotions and partisan politics. We had not anticipated the level of legislative opposition that would be generated from a vocal minority of legislators opposed to health care reform. Our planned community education and dialogue turned out to be too late to avert the challenges presented in the just-ended legislative session in Arkansas. On a positive side, the early stakeholder involvement and dialogue work we *had* begun did result in active support for the Arkansas Benefits Exchange. This support was a key factor in preventing the vocal minority from defeating Exchange planning.

Lessons learned: Widespread constituent and legislator education about an issue is important prior to its coming for a vote among elected officials. A vocal minority was able to effectively

get the attention of legislators who were not hearing from constituents who supported health care reform. It is important that we work closely with supporters and opponents of health care reform, and the Health Benefits Exchange in particular, learning each groups' needs, concerns, and strategies, and design methods for providing them with factual information which may lead to decisions informed by fact instead of emotions or fear based on misinformation. Perhaps an Exchange planning strategy that would have allowed for a year-long public education campaign would have made a difference in gaining citizen support. However, our biennial legislative session structure for non-fiscal issues prevented such an approach as we worked to meet the Affordable Care Act timelines. We will work diligently to effect public education prior to the next Arkansas General Assembly. This year's legislative experience will likely influence our Level One Implementation Funding request to include a greater budget for public outreach and education.

An unrelated barrier to relationship-building occurred when we experienced communication inconsistencies related to our Background Research RFP. When asked the question, an Office of State Procurement (OSP) official informed AID Exchange Planning staff in good faith that a vendor selected for Exchange Planning Background Research would be eligible to also apply for Exchange implementation funding. Based on this OSP answer, the Exchange Planning Project Director told several potential vendors they *could* apply for implementation funding if awarded the Exchange Planning Background Research contract. The OSP decision was later reversed, but *after* the RFP was advertised. This was not helpful for credibility or relationship-building with potential vendors or the State Procurement Office—both important relationships for our work. Some potential vendors changed their plan to submit a Background Research proposal in order to later apply for implementation funding. We asked that all potential vendors be notified of the final ruling. Lesson learned: Get answers to all interagency questions in writing. *We're not actually sure this would have made any difference, as the involved OSP staff member confirmed he had given the (later reversed) advice.* We continue to work with this agency and the same staff and will make concerted effort to prevent such incidents in the future.

Technical Assistance

Specific technical assistance needs are expected to be identified as our Background Research, Stakeholder Involvement, workgroups studies advance. One issue we have identified for technical assistance is, "How will we fund development of Navigator programs without use of Federal planning/implementation funds?" We understand that PPACA does not allow Federal funds to be used in awarding required Navigator grants. Our State will not allow use of State funds for Exchange development or operations. We view Navigator assistance as particularly important in initial outreach and education efforts preparing our population for enrollment in the Arkansas Benefits Exchange. This early period is where there will be no funding. Following consumer enrollment, Navigator grants could be funded through premium or other fees, but how will we pay for pre-2014 education and outreach by Navigators? Any technical assistance in planning and adequately funding the early Navigator program without Federal or State funds will be appreciated.

Work Plan

Background Research

Milestone 1: Define needed Background Research and insert into planning RFP(s) by February 10, 2011. *Background Research Scope of Work was defined by Exchange Planning staff, reviewed by colleagues, and submitted to the Arkansas Office of State Procurement (OSP) on February 14, 2011. The draft document was reviewed by the AID Life and Health Division Director, staff attorney, AID Commissioner, and external partners working on integrated information technology planning for Arkansas health system improvements including the Health Benefits Exchange.*

Milestone 2: Planning contract(s) will be in force no later than June 1, 2011. *We expect the Arkansas Benefits Exchange Background Research contract to be in force no later than June 1, 2011. The appropriation for this RFP vendor contract is in place. However, based on Exchange Planning controversy occurring during the 88th Arkansas General Assembly, the Insurance Commissioner will work in advance to provide information to reviewing legislators in order to expedite contract approval.*

Milestone 3: To insure transparency and broad stakeholder involvement, contractor(s) monthly progress reports will be shared with diverse stakeholders and advisory groups via meetings, web site, email distribution lists, etc.

Milestone 4: Staff will continuously review literature and other information from multiple sources to prepare for active participation with contractors and stakeholders, and to evaluate background research findings and recommendations. *Exchange planning director and specialist will attend CCIIO Grantee meeting in Denver and Utah Exchange Learning Session in Salt Lake City – both in May, 2011.*

Stakeholder Involvement

Milestone 1: Define scope of work/deliverables for stakeholder research and have interagency agreement between the AID and UAMS complete by February, 15, 2011. *Scope of Work/Deliverables document for Stakeholder Inclusion contract with UAMS was finalized during the 2nd reporting period and agreed to by UAMS (Partners and COPH) and AID representatives (see attachment 2). Some due dates were delayed due to later than anticipated contract execution. The intergovernmental agreement is expected to be executed in April. Initial interviews and community meetings will be conducted by June and a preliminary Stakeholder report completed by July. This Stakeholder Inclusion team will collaborate with Background Research vendor and AID Exchange Workgroups and participate in fall 2011 Stakeholder Summit. Year One Stakeholder Recommendations are expected by November, 2011.*

Milestone 2: The Arkansas Insurance Department (AID) will develop and staff active, inclusive workgroups to advise Arkansas Benefits Exchange planning by the end of February, 2011. These groups will include: 1) Consumers; 2) health insurance carriers and health care providers including practitioners, hospitals, and associations; 3) small business and community leaders including legislators and other policymakers; 4) outreach, education, and enrollment providers including navigators, producers, and brokers; and 5) State agencies. Key issues to be discussed will include: Governance; transparency; stakeholder inclusion; encouraging competition and participation among carriers; data driven innovations to improve health and thereby lower insurance costs; outreach and enrollment of consumers including small businesses; data security with eligibility and enrollment determinations and movement between coverage with life changes; and evaluation. *Participants for five different Exchange Planning workgroups were identified and recruited in February and March, 2011. Almost everyone approached about workgroup participation agreed to do so. The group sizes have grown to a number greater than originally planned; however, we decided to err toward inclusion. More than 80 workgroup members have committed to this important work. The launch of these workgroups was delayed until the end of the 2011 Legislative Session. Workgroup orientation sessions will include member introductions, information on Affordable Care Act and Exchange Requirements, and agreement on a process for achieving work.*

Milestone 3: Insure transparency and inclusion in workgroup activities by timely dissemination of information via web site and other modalities and open, inclusive meetings. We will explore use of interactive video to reach out to communities outside central Arkansas. *Meeting summaries for each workgroup will be posted on the AID Exchange Planning Website following the meetings. Visitors will be allowed to attend all meetings which shall be open. AID Exchange Planning Staff will be available between meetings to answer questions and serve as a resource for information gathering/planning. The State Department of Information Services has agreed to assist with interactive video methods that could allow persons in outying communities to participate without spending a day driving to Little Rock and back.*

Milestone 4: Provide for inter-workgroup sharing of information via staff, multi-media, and stakeholder summit. *This will include posting of workgroup summaries and other Exchange planning resources on the AID Exchange website.*

Program Integration

Milestone 1: Begin discussions with key agency leadership about "no wrong door" to integrated eligibility/enrollment portal. There is key agency agreement on how the technical aspects and rules engines will be organized, developed and integrated. A follow-up meeting is being convened between the Arkansas Insurance Department, Arkansas Department of Information Services, Arkansas Department of Human Services, and Arkansas Health Information Technology (SHARE). *The AID presented a Health Benefits Exchange progress update to the HIT Council. The State Agency Workgroup is expected to address program and technical*

infrastructure integration issues to ensure the Arkansas Benefits Exchange provides appropriate services, choice, products, prices, and security. We expect to launch a sixth Workgroup on Health Benefits Exchange IT Needs/Gaps Analysis in the third grant quarter.

Milestone 2: Establish an interagency MOU between the AID, DHS, HIT, and DIS by March 1, 2011 to outline responsibilities and timeframes for operationalizing the integrated Health Benefits Exchange portal by July 1, 2013, and for ongoing technical architecture assessment, design, and improvements to include cost accounting. *A full MOU outlining collaborating agencies responsibilities for the Health Benefits Exchange has not been drafted. However, a timeline with deliverables was created by the Health Information Technology Director with input from each named agency. The State's Single Sign-On Authentication Project has held weekly meetings to define a technology-based, secure Health Information System that will improve the health care experience for patients, providers, and consumers. (See Attachment 8 for Draft Agreement). This workplan has been signed by participating agency representatives, including AID. A planning document is expected to be signed by Medicaid, HIT, HIS, and AID-Exchange Planning Directors in April, 2011. The next step will be to determine costs.*

Milestone 3: Planning grant contractor(s) will begin work with private insurance carriers and State inter-agency workgroups to determine technical infrastructure needs for integrated eligibility/verification/enrollment/subsidy determination/premium payment and re-enrollment options through the Arkansas Health Benefits Exchange. *Private carriers and State Agency leaders have been notified of the Exchange Planning process and that Background Research and/or Stakeholder Involvement researchers are likely to contact them for an interview. The process has been shared verbally (including by one of the UAMS contractors) and in writing through Orientation or other processes. As stated above, an Exchange Information Technology Workgroup will be launched by May to focus on Exchange IT gaps and needs.*

Milestone 4: Begin interagency exploration of other public-private programmatic integration interest for services such as consumer outreach and education, call center, and integrated eligibility/enrollment/re-enrollment/change options with other public programs such as SNAP, TANF, etc. *Discussions about pros and cons of Health Benefits Exchange playing a role in eligibility/enrollment into other (non health coverage) low income social supports such as TANF or SNAP are expected to begin early in the life of Workgroups discussions.*

Milestone 5: Beginning in the second grant quarter, explore lessons learned, overlap functions, or potential areas of synergy or integration between the Arkansas Insurance Department SHIIP Program, Consumer Assistance Program, and to-be-developed Exchange Call Center. *Leaders of the three CCIIO Health Care Reform Grants (Exchange Planning, Premium Rate Review, and Consumer Assistance Program) have begun meeting monthly on first Mondays to share activities/questions/needs/potential areas of coordination. We expect to identify synergistic*

activities. We are considering broadening the internal Health Care Reform coordination group to include Senior Health Insurance Information Program (SHIIP) leadership, as we expect to learn implementation pitfalls to avoid from the State's implementation of Medicare Advantage and Prescription Part D programs. It is too early to address potential call center operations.

Milestone 6: If Secretary Sebelius approves a waiver to implement the proposed Arkansas Health Systems Payment Reform Pilot, we will explore with key partners whether and how such a pilot would interface with the developing AR Health Benefits Exchange.

Resources & Capabilities

Milestone 1: Issue Background Research planning RFP in February 2011 to include identification of needed resources and capabilities for cost effective Health Benefits Exchange operations that will provide excellent value and service for consumers, including understandable information. *The Background Research RFP was officially issued on March 14 versus the expected February 28th.*

Milestone 2: Continually assess and update estimated annual costs for implementation and continuing operations of Arkansas Health Benefits Exchange. Estimates will be based on ongoing research, lessons learned, and consultation with exchange experts and other state exchange implementation leaders.

Milestone 3: Advisory workgroups will identify potential non-federal, non-state general revenue options for funding ongoing Exchange operations for consideration along with options identified by consultant contractors.

Milestone 4: Contractors and advisory workgroups will begin to identify outcomes metrics for ongoing Exchange performance improvement.

Governance

Milestone 1: AID and multiple stakeholders will support enabling legislation during the 2011 session of the AR General Assembly that will provide broad Exchange governance and rule-making authority to the Arkansas Insurance Department. *Legislation authorizing the Arkansas Health Benefits Exchange was not passed during the 2011 Arkansas General Assembly. (See* Regulatory and Policy Actions *above*). *Arkansas's 2012 Legislative Session is a fiscal-only session. The Governor determines the legislative package for a fiscal session and we do not anticipate Exchange Authority being on the agenda. At this time, we do not believe the Governor is likely to call a special legislative session to address establishment of the Arkansas Benefits Exchange. While we are confident of continued and robust Exchange planning activities, and our ability to eventually prevail in establishing state authority for the Arkansas Benefits Exchange, we are concerned about the timing. Not being able to obtain CCIIO Phase Two Implementation Funds until after the Legislature meets in the Spring of 2013 delays critical*

implementation activities until too late for achieving our self-imposed deadline of having a fully operational Exchange by July 1, 2013—which would leave us time for correcting any implementation errors prior to our January 1, 2014 coverage deadline. We will be exploring how to achieve as much readiness as possible through Phase One Implementation Funding.

Milestone 2: Multiple stakeholders will participate in workgroups that study governance options and provide the Insurance Commissioner, AID Exchange planning staff, and others with pros and cons of various governance options for the Arkansas Health Benefits Exchange that meet the Governor's directives for AID authority and no new state costs, and the Federal requirements for transparency and world class Exchange services offering "no wrong door" to consumers, subsidy determinations, and choice in selecting qualified health plans and enrolling/re-enrolling with appropriate subsidies.

Milestone 3: Finalize governance and administrative structure for Arkansas Health Benefits Exchange by fourth grant quarter with appointment of developmental and/or inaugural Exchange board and advisory group(s). *Due to failure of legislative authority defining governance of the Arkansas Health Benefits Exchange, work will continue with the Arkansas Insurance Commissioner and Governor to establish other viable options to support efficient Exchange planning and development.*

Milestone 4: Work with CCIIO to develop a viable funding and approval plan for Arkansas to move forward with Exchange implementation after January 1, 2013.

Finance

Milestone 1: Identify financial components to be included in Planning RFPs to be issued in February 2011. *This was accomplished with financial components included in Scope of Work.*

Milestone 2: Evaluate and update Background Research contractor cost estimates for viable Exchange development and ongoing operations, to include staffing, technical and operations costs including consumer education, and possible sources for sustainability revenue. *Background Research contract expected to be awarded by June 1, 2011 with finance work achieved over the summer months.*

Milestone 3: Contractor to develop financial management policies and procedures to include conflict of interest, fraud, waste and abuse prevention, and auditing standards. *Background Research contract expected to be awarded by June 1, 2011 with financial management policies and procedures recommendations completed by August 31, 2011.*

Technical Infrastructure

Milestone 1 **:** Identify RFP requirements to study complete technical architecture and infrastructure needs and cost sharing for functional Exchange, to include integration with MMIS, Federal portal, Access Arkansas, SHARE, private carriers, and other key systems. *Exchange Planning staff worked with other state agencies on IT needs during the past quarter. Staff from*

key agencies reviewed "technical infrastructure" language for our background research RFP. Representatives from the State's Office of Health Information Technology (HIT) and Department of Information Systems (DIS) have met together with potential vendors expecting to bid on MMIS, Exchange, or Health Information Exchange projects. All know the need for accurate cost allocations to achieve accurate cost sharing.

Milestone 2: Ensure through formal agreements, contractor and agency meetings, and continuously open communication channels that key agencies and contractor(s) are updating one another in a timely manner on needs, gaps, and cost determinations/allocations for development and ongoing operations of an efficient, user-friendly Exchange connecting with Access Arkansas and SHARE. *This is ongoing. We have made progress with a Single Sign-On Security Solution for multiple users needing health information access and sharing. An Interagency Agreement is in the process of being signed (see Attachment 8).*

Milestone 3: Determine technical architecture/infrastructure needs and estimated costs for technical connections between integrated Exchange eligibility/enrollment portal and cost centers, private plans, consumers, consumer guidance and selection navigators, enrollment, and premium collections for non-Medicaid enrollees. This will include review of DHHS CCIIO-CMS technical bulletins. *We have continued work with HIT and DIS leaders and have worked on Single Sign On Security Requirements. Dialogue has begun with private carriers about technical infrastructure needs and how the Exchange might provide administrative efficiencies for them. Carriers have expressed interest in an All Claims Data base and are welcoming discussions with the state's HIT Director to design the virtual structure for a master patient (person) index and master patient file.*

Milestone 4: Launch an Interagency Exchange IT Workgroup during the third quarter in collaboration with Office of HIE and DIS.

Business Operations

Milestone 1: Define Exchange business operations components to be included in RFP to be issued February, 2011. These will include operational components needed regardless of administrative/governance plan selected, such as: plan certifications, re-certifications and de-certifications; standardized format for presenting plan options; financial integrity and oversight compliance functions; risk adjustment; outreach and education to include hotline, call center, navigator program(s); eligibility, enrollment, and appeal processes including integration with federal, state, and private sector systems and business rules, and premium/subsidy calculators; consumer choice; and others to be determined through contractor and stakeholder input. *Exchange Background Research RFP included requirements for studying and making recommendations on Arkansas Benefits Exchange Business Operations*

Milestone 2: Ensure ongoing communications between contractors, planning staff and stakeholders regarding business operations components through reporting and other information dissemination.

Milestone 3: .Determine cost estimates for functional Exchange to include break-even analyses for start-up and ongoing business operations and quality improvements.

Milestone 4: Identify viable options for ongoing Exchange funding.

Regulatory or Policy Actions

Milestone 1: The AID will obtain broad rule-making authority for implementation of the Arkansas Health Benefits Exchange during the 88th Arkansas General Assembly. *The AID did not achieve this goal during the 88th Arkansas General Assembly which ended in mid-April, 2011. We are in the early days of planning next steps to achieve necessary regulatory authority to move forward in developing Arkansas's Health Benefits Exchange.*

Milestone 2: Arkansas Insurance Department and other stakeholders will educate legislators and other policymakers about the advantages and desire for a state run Arkansas Benefits Exchange unless early studies by contractors and stakeholders unexpectedly determine otherwise.

Milestone 3: Multiple stakeholders will support the Governor's directive for the Health Benefits Exchange to ultimately be regulated by the Arkansas Insurance Department with the specific governance model to be determined, including consideration of an option for a quasi-governmental body reporting to the AID.

Milestone 4: Exchange governance and operations will be in compliance with state and federal law and guided by informed stakeholders, including consumers and expert contractors.

Collaborations/Partnerships

Collaborative partnerships are emerging with multiple stakeholders, including (to date and alphabetical):

- **AARP Arkansas - Herb Sanderson, Associate Director and Policy Leader**
  Mary Dillard, President
  Role: Help Arkansans age 50 and over improve their quality of life. Herb Sanderson testified for HB2138 and the Arkansas Health Benefits Exchange. He is serving on the Exchange Planning Consumer Workgroup.
  Potential Barrier: AARP-Arkansas and AARP- national lost members over the health care reform issue. We believe education of our older citizens in collaboration with AARP-Arkansas will help older Arkansans better understand the value of the Arkansas Health Benefits Exchange.

- **Arkansas Advocates for Children and Families – Elisabeth W. Burak, Director of Health Policy and Legislative Affairs**
  Role: Advocacy organization serving as a consumer advocate for access to quality, affordable health care. Expected to support AID regulatory position for Health Benefits Exchange and serve as non-partisan advocate for children and families in need of health

benefits coverage—particularly for low income and CHIP eligible individuals. Grassroots advocacy approach differs from "grass tops" approach and can bring otherwise unheard voices to Exchange planning. *Elizabeth Barak testified for HB 2138 in House Insurance and Commerce Committee. Arkansas Advocates sent email flyers to their statewide e-mail list of grass-roots advocates seeking support for the Exchange and kept stakeholders updated on legislative actions.*
Potential Barrier: Could end up at odds with Exchange over some issues such as minimal essential benefits or methods of consumer outreach.

- **Arkansas Center for Health Improvement – Joe Thompson, MD, Director**
  Role: Home of Arkansas's Surgeon General who has defined "three legs of health care reform stool" to be: Health Benefits Exchange, Health Information Technology, and Workforce Development. Convened a group to discuss Arkansas' Health Benefits Exchange that included Governor's staff, State Coverage Initiative Consultants and State Agency Executives for Health, Human Services, Insurance, Finance and Administration (Employee Benefits Division and Health Information Technology) Departments. *Surgeon General Joe Thompson testified for HB 2138 in the House Insurance and Commerce Committee. He has appointed David Boling, an attorney and former U.S Congressional staff member, to serve as liaison for Arkansas Health Benefits Exchange. During the reporting period, ACHI unsuccessfully sought additional Technical Assistance funding for the developing Arkansas Health Benefits Exchanges from the Robert Wood Johnson Foundation.*
  Potential Barrier: Multiple priorities and timeframes for health care reform and access issues.

- **Arkansas Department of Human Services (DHS) - John Selig, Director**
  - **Division of Medical Services (Medicaid) – Gene Gessow, Director**
  - **Division of County Operations (Program E/E) – Joni Jones, Director**
  - **Division of Information Support (IS) – Dick Wyatt, Director**

  Role: Key in establishing single enrollment/eligibility (E/E) portal and consumer enrollment services. Agreed on structure for Arkansas Health Benefits Exchange single eligibility/ enrollment portal with Access Arkansas as platform; committed to ongoing development. DHS Medicaid and County Operations Staff are beginning meaningful discussions with Exchange Planning staff about key enrollment/re-enrollment and continuity of coverage/care issues ranging from churning challenges to how to achieve streamlined open enrollment periods, income verification, etc.
  Potential barrier: A new MMIS system being built; should not pose a barrier as modular approach to portal is planned and timeframes for Health Benefits Exchange start-up are clear. *The Department of Human Services has proposed a bold payment reform waiver to Secretary Sebilius that would integrate Medicaid, Medicare, and Private insurance funding into a bundled services, managed care approach that would fund episodes of evidence-based care using a health home model. This plan has met initial opposition from organized medicine. It is likely to divert much staff time needed for planning the Health Benefits Exchange—and certainly the time of the State Medicaid Director and his staff who are also key to successful Arkansas Benefits Exchange Development. A preliminary answer is expected by Secretary Sebilius by May 1, 2011. We will need to begin evaluating how this health care transformation model will affect the developing Health Benefits Exchange and our developmental timeline as soon as Arkansas has an answer.*

- **Arkansas Division of Information Systems – Claire Bailey, Director**
  Role: Key in establishing technical and security architecture and infrastructure to support single Exchange portal and broader health care reform architecture/rules development and implementation, including quality metrics plans.
  Potential barrier: Multiple State IT priorities. *DIS has provided strong leadership by Chief Security Officer Kym Patterson to define multi-agency needs and timelines for a single security sign-on solution that will serve the Arkansas Benefits Exchange. An interagency agreement has been drafted and is expected to be signed in April, 2011. DIS leadership staff, including Director Bailey, have attended multiple meetings with Health Exchange Planning and other State Agency Staff (e.g. Medicaid, HIT) where potential information technology vendors presented their products as potential solutions for the developing Arkansas Benefits Exchange-- in order to assist AID in evaluating products and in ensuring that various health improvement initiatives select solutions that work across State government in an efficient, non-duplicative, cost-effective, and collaborative manner.*

- **Arkansas Employees Benefit Division (EBD) of DF&A – Jason Lee, Executive Director**
  Role: Administers the State Employees and Public Schools' Health Benefits Plan, and has State knowledge and operations experience, including enrolling individuals and working with Arkansas private carriers, that could be transferable to Exchange development. *We met with EBD Executive Director and Chief Operations Officer to learn more about their operation and where there may be areas of synergy with the developing Health Benefits Exchange.*
  Potential barrier: Limited experience with individual outreach and overall marketing, as EBD has captive (large group) market. They are self-insured.

- **Arkansas Foundation for Medical Care – Ray Hanley, CEO**
  Role: A nonprofit program to improve health care in Arkansas, including through Medicare and Medicaid improvement programs. AFMC has expertise in health care quality improvement and will be able to assist Arkansas in developing metrics for monitoring health services and outcome improvements. Ray Hanley testified in support of HB2138 and Arkansas Health Benefits Exchange development. He also recently provided advocacy for the Health Benefits Exchange on a conservative talk radio show in Little Rock.
  Potential barrier: Health care provider groups concerns relative to ensuring adequate payments to accomplish evidence-based, quality of care improvements.

- **Arkansas Health Care Reform Education and Advisory Board**
  Role: A self-chartered group of key stakeholders that includes CEOs of Arkansas's major health and dental insurance carriers (Blue Cross/Blue Shield of Arkansas, United, QualChoice, Delta Dental), association executives (medical, nursing, dental, pharmacy, hospital), State Chamber of Commerce and an employer and desires to advise Exchange development process. Expected to support the AID governance of Exchange. *This self-chartered group stepped up their work in preparation for and during the Arkansas General Assembly. They met weekly to develop Guiding Principles for their work and subsequent legislative recommendations. They reviewed the AID Exchange enabling legislation drafts and provided feedback which resulted in some language changes regarding Exchanges and Premium Rate Review in HB 2138. At the time of Legislative action, Group members*

received legislative alerts encouraging action in support of the Arkansas Health Benefits Exchange and HB 2138. Some individual members of this group provided additional support through their respective organizations. There were some issues (including Exchange governance) that the group could not reach consensus on. The group will continue to meet monthly and Exchange Planning staff will attend. Some members of this advisory group are also serving on the AID Exchange Planning Workgroups.
Potential barrier: Diverse views of members could result in lack of consensus. Individuals from this group have agreed to also participate with others advising Exchange development.

- **Arkansas Health Information Technology - Ray Scott, Director**
  Role: Serves as State coordinator for Health IT efforts. Key in establishing single enrollment/eligibility portal and development of master index for consumers to include demographic data. Committed to effort. *The Office of Health Information Technology (HIT) was established during the 88th Arkansas General Assembly. Director Ray Scott has continued to meet with Exchange Planning leadership and potential vendors to coordinate potential Exchange design and interface opportunities within the broader Arkansas HIT (SHARE) framework.*
  Potential barrier: Magnitude and priorities of other HIT work relative to health care reform.

- **Arkansas Hospital Association – Bo Ryall, CEO**
  Role: Represents hospital providers in health care reform. Expected to support Exchange development and governance plan. *CEO testified in support of Arkansas Benefits Exchange and HB2138 in the Insurance and Commerce Committee meeting.*
  Potential barrier: financial concerns with health care reform implementation. *The AHA has expressed concern over the developing Medicaid-Medicare-Private insurance waiver plan. We will work to retain this valued partner in promoting the best possible Health Benefits Exchange for Arkansans. We also need to be prepared to discuss Accountable Care Organizations with the AHA.*

- **Arkansas Insurance Commissioner's Task Force – Jay Bradford, Chair**
  Role: Broad stakeholder group including Governor's office staff and legislators, state agency staff, insurance carriers and producers, legal community, professional associations, government relations staff, reporters and others. Discuss key issues with Commissioner, most recently health care reform legislative plans. Expected to support Commissioner and AID authority for broad rule-making.
  Potential Barrier: Potential change of Commissioner is concern of Task Force members as the position is a political appointment.

- **Arkansas Nurses Association - Darlene Byrd, APN, Health Policy Chair**
  Linda McIntosh, APN, President Elect
  Role: The voice of Arkansas nursing: Promoting access to affordable, quality, healthcare. Members are serving on Exchange Planning Workgroups. IOM report promotes Advanced Practice Nurses practicing up to full scope of practice.
  Potential Barrier: Relatively new to health care financing decision-making table—will need to establish relationships with other groups.

- **Community Health Centers of Arkansas – Sip Mouden, CEO**
  Role: Statewide Federally Qualified Health Center Association desires to assist with consumer outreach during Exchange Development. *Has agreed to serve on Exchange Planning Outreach/Education Workgroup.*
  Potential barrier – multiple competing funding and health care delivery priorities.

- **Community Mental Health Centers of Arkansas – Pam Christy, CEO**
  Role: Statewide advocate for behavioral health parity and coverage for low income Arkansans through the Exchange. *At Association request, the Exchange Planning Director presented information on Health Benefits Exchange to their statewide membership during the second quarter. Representatives will serve on the Exchange Planning Provider Workgroup.*
  Potential Barrier: How behavioral health services will be defined as part of minimal essential benefits.

- **University of Arkansas for Medical Sciences**
  College of Public Health – Dr. John Wayne, Health Policy and Management
  Partners for Inclusive Communities – G. David Deere, Director
  Role: Plan to work together and with Arkansas Center for Health Improvement and others to design and implement initial stakeholder data gathering processes to include industry and consumer groups. Dr. Wayne has a background in health care policy, including experience with insurance. Mr. Deere has background in serving disability communities and other underserved populations. Both have extensive experience with stakeholder research including focus groups and key-informant interviews. *Interagency agreement is being executed for work as planned. Students are also to be involved. Mr. Deere met with the Health Care Reform Education and Advisory Committee to describe the upcoming data collection process. A representative of this group plans to attend each Exchange Planning Workgroup session.*
  Potential barrier: Perception that their work represents "provider" side of UAMS.

In addition to the collaborating partners listed above, we have met multiple times with others seeking to influence the Arkansas Health Benefits Exchange development. We have listened to concerns and invited continued participation through our Exchange Planning Workgroups. Those that we have met with more than once are:

- Delta Dental of Arkansas – Ed Choate, CEO
- Christian Science Committee on Publication for Arkansas – Joe Pelphrey
- United Food and Commercial Workers Union – Gene Mechanic and Steve Gelios

We have also met with multiple potential vendors wanting to provide information technology, administrative services, and even Qualified Health Plans. Those we have met with during the second reporting period include:

- Aon Hewitt
- Blue Cross Blue Shield
- Connecture/Maximus
- Benefit-Focus

- Fox-Cognosante
- Get Insured
- HealthSource
- Oracle
- Xerox/ACS/Choice Administrators

Finally, we would like to recognize CCIIO staff, ranging from Exchange Planning Director Ario to Arkansas Project Officer Wise and others for being responsive to State inquiries and needs. When quick responses were needed during Arkansas's legislative session, we were able to obtain them immediately. We very much appreciate staff availability and the timeliness of responses. Washington CCIIO staff members demonstrate a true caring for grantees and project outcomes. For them, as for us, this work is more than a "job"; it's a meaningful, "movement" toward essential change for the economic and personal health of our nation. We also appreciate CCIIO support in connecting grantees for information sharing and peer support.

ATTACHMENT 1

FEDERAL FINANCIAL REPORT

(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted	2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment)	Page	of
DHHS - CCIIO	1 HBEIE100001-01-00	1	1 pages

3. Recipient Organization (Name and complete address including Zip code)

Arkansas Insurance Department
1200 West 3rd Street, Little Rock, AR 72201-1904

4a. DUNS Number	4b. EIN	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment)	6. Report Type	7. Basis of Accounting
81501558	71-0847443		◉ Quarterly ○ Semi-Annual ○ Annual ○ Final	☒ Cash ☐ Accrual

8. Project/Grant Period From: (Month, Day, Year)	To: (Month, Day, Year)	9. Reporting Period End Date (Month, Day, Year)
09/30/2010	09/29/2011	03/31/2011

10. **Transactions**	Cumulative
(Use lines a-c for single or multiple grant reporting)	
Federal Cash (To report multiple grants, also use FFR Attachment):	
a. Cash Receipts	68907.06
b. Cash Disbursements	49476.41
c. Cash on Hand (line a minus b)	19430.65
(Use lines d-o for single grant reporting)	
Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	1,000,000.00
e. Federal share of expenditures	49,476.41
f. Federal share of unliquidated obligations	-
g. Total Federal share (sum of lines e and f)	49,476.41
h. Unobligated balance of Federal funds (line d minus g)	950,523.59
Recipient Share:	
i. Total recipient share required	
j. Recipient share of expenditures	
k. Remaining recipient share to be provided (line i minus j)	
Program Income:	
l. Total Federal program income earned	
m. Program income expended in accordance with the deduction alternative	
n. Program income expended in accordance with the addition alternative	
o. Unexpended program income (line l minus line m or line n)	

11. Indirect Expense	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share
	N/A	N/A	10/01/2010	03/31/2011	N/A	-	-
				g. Totals:	-	-	-

12. *Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation:*

13. Certification: By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and intent set forth in the award documents. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)

a. Typed or Printed Name and Title of Authorized Certifying Official	c. Telephone (Area code, number and extension)
Jay Bradford Commissioner	501-371-2621
	d. Email address Jay.Bradford@Arkansas.Gov
b. Signature of Authorized Certifying Official	e. Date Report Submitted (Month, Day, Year) April 15, 2011
	14. Agency use only:

Standard Form 425 - Revised 6/28/2010
OMB Approval Number: 0348-0061
Expiration Date: 10/31/2011

DRAFT

Intergovernmental Agreement
between
Arkansas Insurance Department and University of Arkansas for Medical Sciences

SCOPE OF WORK WITH BUDGET JUSTIFICATION

UAMS Partners for Inclusive Communities (Partners) has the expertise, experience, and relationships needed to assist Arkansas Insurance Department (AID) in planning for Arkansas's Health Insurance Exchange by facilitating meaningful stakeholder involvement in the year-long planning process. Funds from the DHHS Center for Consumer Information and Insurance Oversight were awarded to AID for this purpose. AID will enter into an intergovernmental agreement with UAMS Partners for stakeholder recruitment, engagement and interviews, data collection and reporting services.

Partners will collaborate with the UAMS College of Public Health to implement a plan to recruit and dialogue with diverse stakeholders including consumers, providers, agencies, and policymakers to both inform stakeholders about the development of Arkansas's Health Insurance Exchange and receive feedback from stakeholders about their ideas, concerns and potential barriers to implementing an acceptable, accessible, and cost efficient health insurance exchange.

Deliverables for the seven month period from May 1, 2011 – November 30, 2011 (also see budget narrative for additional detail) are:

1. Key informant interviews will be held with insurance carriers, health care providers, and key agency leaders to collect data on stakeholders' knowledge, concerns, and identified issues that promote or inhibit development of the Arkansas Health Benefits Exchange. These will be completed by May 2011.
2. Community meetings will be held in 15 communities across the state, with a minimum of three meetings in each Congressional District. In each community, the assessment team will hold separate meetings with consumers, business and community leaders, and health care providers/insurance carriers to both inform them on Health Benefits Exchange responsibilities and obtain feedback about participants' views on development of Arkansas's Health Benefits Exchange. Language interpreters will be provided as needed. This will be completed by June 30, 2011.
3. Report initial stakeholder input to AID staff and other Exchange Study Groups (e.g., Background Research Vendor and Exchange Planning workgroups) using digital and/or verbal methods as requested. This will be completed by July 31, 2011.
4. Participation in the Arkansas Health Benefits Exchange Summit (October, 2011). This will include having printed 250 copies of draft report of stakeholder recommendations.
5. Written report (250 copies) of stakeholder recommendations about operation of the AR Insurance Exchange based on stakeholder input by November 15, 2011. This report will include a digital format and be written in a way that is understandable to multiple stakeholders.

Approval Initials: AID _____UAMS_____

6. Participate in public hearings in each Congressional District to solicit community feedback on the report and stakeholder recommendations.
7. Report information to and receive information from the Exchange Background Research Vendor and AID Exchange Planning Workgroups to provide information flow to and from other stakeholder research activities through the life of the project.

Summary Timeline of Deliverables

DELIVERABLE	DUE DATE
1. Key informant interviews.	5/31/11
2. Community meetings in 15 communities	6/30/11
3. Initial stakeholder report to AID, background research vendor, and workgroups	7/31/11
4. Participation in Stakeholder Summit, including draft stakeholder report	10/31/11
5. Report of Stakeholder Recommendations (250 copies)	11/15/11
6. Participate in Public Hearings in each Congressional District	As scheduled by AID
7. Ongoing communication with AID, background research vendor and exchange planning workgroups.	Ongoing

Budget Justification

Personnel Costs: ($29.634)

David Deere, M.S.W., M.Th., is the Principal Investigator and will provide general oversight to the project, taking responsibility for all activities and reporting. He will devote 19% (18.86%) of his time to the project for the seven month period from May 1, 2011 – November 30, 2011. Of his $96,328 projected annual salary, $10,596 is requested from the project. His fringe benefit costs are $1,907.

John Wayne, Ph.D. is a co-investigator who will assist in designing and conducting the project. He will devote 18.86% of his time to the project for the seven month period of May 1, 2011 through November 30, 2011. His projected annual salary is $122,624. The project requests $13,489 for his salary support. His fringe benefit costs are $3,642.

Supplies: ($598) The project will produce a draft report for each of the 250 participants in the Health Care Summit at a cost of $2.39 per person.

Travel: **($12,416)** Local travel to 20 community meetings for 3 vehicles with an average distance of 350 miles round trip is calculated at 21,000 miles at $0.42 a mile ($8,820). Overnight lodging and food is projected to cost $3596 (31 overnight stays at $116 per day). Travelers will be reimbursed for actual expenses.

Other: ($19,749) The project will provide $25 incentives to 150 health care consumers who participate in community meetings for a cost of $3750. It will also provide snacks to 500 participants in community meetings at a cost of $5 per person and a meal to 250 participants in a Health Care Summit at a cost of $20 per person. The total cost for food will be $7,500. Note takers for the community meetings will receive $100 for each meeting for a total cost of $4500. The cost of printing 250 final reports at a cost of $4 each will result in a total cost of $1000. At a

total cost of $500, advertising will be placed in local newspapers to inform residents of community meetings. The project will use the UAMS distance technology system to connect outlying communities to community meetings. Line charges are estimated at $2499.

Contractual Services: ($16,968) The project will contract with external agencies and individuals to assist with facilitation of meetings, data management and analysis, and report writing. The project will allocate $14,818 for contracts for these services.

As language accommodations are requested for either sign or Spanish language interpreting, the project will provide those accommodations. While the cost will vary depending on the number of requests, the projected costs, based on similar projects, are $2,150.

Indirect Costs: **($20,635)** The federally negotiated rate for indirect costs of off-site projects at UAMS is 26%. This rate is applied to $79,365 for this project.

Total: **$100,000.**

Signatures:

UAMS Title Date	**Jay Bradford, Commissioner Date**
Office of Research and Sponsored Programs	**1200 West 3rd Street**
4301 West Markham Street Arkansas	**Insurance Department**
Little Rock, AR 72205	**Little Rock, AR 72205**

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

State of Arkansas *As Engrossed: H3/21/11 H3/24/11 H3/29/11*
88th General Assembly **A Bill**
Regular Session, 2011 HOUSE BILL 2138

By: Representatives *Allen, Nickels*
By: Senator P. Malone

For An Act To Be Entitled

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

Subtitle

TO ALLOW THE INSURANCE COMMISSIONER TO PROTECT ARKANSANS BY THE CONTINUED LOCAL REGULATION OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

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

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

(a) The Insurance Commissioner shall:

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

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

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

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

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

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

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

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

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

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

(A) Actuarially sound; and

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

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

(A) Historical and projected medical loss ratio;

(B) Changes to covered benefits;

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

(D) Claim trend projections;

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

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

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

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

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

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

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

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

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

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

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

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

approved by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~*date for filing the applicable accident and health policy experience exhibit;*~~

~~*(iv)(a) A guarantee that affected Arkansas policyholders will be issued a proportional refund, based on premium earned of the amount necessary to bring the actual aggregate loss ratio up to the loss ratio standards referred to in subdivision (a)(5)(A)(i) of this section. If nationwide loss ratios are used, then the total amount refunded in Arkansas will equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned in Arkansas on the policy form and divided by the total premium earned in all states on the policy form.*~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(A) Medicare coverage; or~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~23-98-102. Definitions.~~

~~As used in this chapter:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~*23-98-104. Formation of trusts of qualified individuals.*~~

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

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

~~*23-98-105. Issuance of minimum basic benefit policies permitted — Applicability.*~~

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

~~*23-98-106. Minimum basic benefits.*~~

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

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

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

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

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

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

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

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

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

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

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

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

~~*(i) Birth;*~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(D) Continuation of coverage;~~

~~(E) Conversion;~~

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

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

~~(H) Continuation of benefits.~~

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

~~(c) The commissioner may authorize a waiver of any of the policy~~

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

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

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

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

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

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

~~*23-98-107. Disclosure requirements for minimum basic benefit policies. Statute text*~~

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

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

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

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

~~*(4) Acknowledges that the prospective insured, at the time of application for the minimum basic benefit policy, was offered the opportunity*~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 104 — Arkansas Health Benefits Exchange Act

23-104-101. Title.

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

23-104-102. Purpose.

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

23-104-103. Definitions.

As used in this chapter:

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

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

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

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

(ii) Coverage issued as a supplement to liability

insurance;

(iii) Liability insurance, including general liability 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, Pub. L. No. 104-191, under which the benefits for health care services are secondary or incidental to other insurance benefits.

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

(i) Limited dental or vision benefits;

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

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

(D) If the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the benefits and an exclusion of benefits under a 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 the event under a group health plan maintained by the same plan sponsor, "health benefit plan" does not include:

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

(A) An accident and health insurance company;

(B) A health maintenance organization;

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

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

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

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

(6) "Qualified employer" means a small employer that elects to make its full-time employees and some or all of its part-time employees eligible for one (1) or more qualified health plans offered through the Small Business Health Options Program if 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 its eligible employees who are principally employed in this state;

(7) "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 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and § 23-104-107;

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

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

(B) Resides in this state;

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

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

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

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

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

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

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

(C) 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 the employer will employ on business days in the current calendar year.

(D) 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 by reason of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment

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

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

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

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

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

(B) The exchange 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 in this chapter, the exchange shall be exempt from:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) The exchange shall:

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

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

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

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

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

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

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

23-104-105. General requirements.

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

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

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

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

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

The Arkansas Health Benefits Exchange shall:

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

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

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

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

(5) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary of the United States Department of Health and Human Services under section 1311(c)(3) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 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 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

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

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

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

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

(8) 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 it existed on January 1, 2011, and any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

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

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

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

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

(11) 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 (10) 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 it existed on January 1, 2011, 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(c)(2)(C) of the Internal Revenue Code of 1986, as it existed on January 1, 2011, to be unaffordable to the employee or not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

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

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

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

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

(14)(A) Select entities qualified to serve as "Navigators" in accordance with section 1311(i) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 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 it existed on January 1, 2011, and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended

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

(iii) Facilitate enrollment in qualified health plans;

(iv) Provide referrals to any 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. § 201 et seq., as it existed on January 1, 2011, or 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 health benefit plan or coverage;

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

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

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

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

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

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

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

(A) Educated health care consumers who are enrollees in

qualified health plans;

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

(C) The commissioner;

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

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

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

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

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

(18) Meet the following financial integrity requirements:

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

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

(i) Investigate the affairs of the exchange;

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

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

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

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

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

23-104-107. Health benefit plan certification.

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

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

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

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

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

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

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

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

(5) The health carrier offering the plan:

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

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

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

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

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

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

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

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

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

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

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

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

(c) Presumption of Best Interest.

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

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

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

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

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

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

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

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

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

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

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

(vi) Data on rating practices;

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

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

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

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

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

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

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

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

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

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

(f) Appeal of Decertification or Denial of Certification.

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

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

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

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

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

23-104-108. Choice.

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

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

(c) Risk Pooling.

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

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

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

(d) Empowering Consumer Choice.

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

(A) This chapter shall not prohibit:

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

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

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

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

(2) Voluntary Nature of the Exchange.

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

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

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

(e) Enrollment through Agents or Brokers.

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

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

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

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

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

2015.

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

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

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

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

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

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

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

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

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

23-104-110. Rules.

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

(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 title I, subtitle D of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

23-104-111. Relation to other laws.

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

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

23-104-112. Plan of operation.

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

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

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

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

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

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

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

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

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

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

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

SECTION 8. LEGISLATIVE CONSTRUCTION AND INTENT.

(a) The General Assembly declares that:

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

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

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

SECTION 9. EFFECTIVE DATE.

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

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

(2) November 15, 2011.

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

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

(2) November 15, 2011.

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

/s/Allen

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

State of Arkansas
88th General Assembly
Regular Session, 2011

A Bill

SENATE BILL 709

By: Senators Irvin, Bledsoe, G. Baker, Rapert, Files, J. Hutchinson, M. Lamoureux, E. Williams, Holland, J. Dismang, J. Key, B. Sample, Whitaker, Hendren, B. Pritchard
By: Representatives J. Burris, Baird, Benedict, Biviano, Clemmer, Dale, Deffenbaugh, English, Eubanks, Garner, Hammer, Harris, Hickerson, Hobbs, Hopper, Hubbard, D. Hutchinson, Johnston, Lea, Mauch, D. Meeks, S. Meeks, Rice, Sanders

For An Act To Be Entitled

AN ACT TO CREATE THE HEALTHCARE REFORM ACCOUNTABILITY ACT; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO CREATE THE HEALTHCARE REFORM ACCOUNTABILITY ACT AND TO DECLARE AN EMERGENCY.

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

SECTION 1. Arkansas Code Title 25, Chapter 1 is amended to add an additional subchapter to read as follows:

Subchapter 4 — The Healthcare Reform Accountability Act

25-1-401. Title.

This subchapter shall be known and may be cited as the "Healthcare Reform Accountability Act".

25-1-402. Findings.

The General Assembly finds that:

(1) State officers are not agents of the federal government;

(2) The Federal Government may neither issue directives requiring the states to address particular problems nor command the states'

officers or those of their political subdivisions to administer or enforce a federal regulatory program;

(3) Congressional mandates to the states to enact or enforce a federal regulatory program are fundamentally incompatible with our constitutional system of dual sovereignty;

(4) The holdings of the United States Supreme Court cited in this section, from Printz v. United States, 521 US 898 - 1997, underlie the American system of dual sovereignty; and

(5) The United States Supreme Court has repeatedly held that the federal government may not commandeer the political authority of the states in order to enact or enforce a federal regulatory program.

25-1-403. Requirements for state agency enforcement of the Patient Protection and Affordable Care Act.

(a) A department or agency of this state shall not implement or enforce any part of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, unless:

(1) The department or agency reports to the legislature under subsection (b) of this section; and

(2) The department or agency is specifically authorized under existing state legislation, state rules, or some combination of the two (2) to implement or enforce the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

(b) The reports required under subsection (a) of this section shall include without limitation:

(1)(A) The specific Arkansas authorization under existing state legislation, state rules, or some combination of the two (2) to implement and enforce the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148; and

(B) The specific provision of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, that is to be implemented or enforced;

(2) Whether the provision of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148 to be implemented and enforced allows for a state waiver or any other alternatives to the federal provision;

(3) An explanation of the nature of the duty or duties created

by that provision of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and an explanation of how that duty or duties will be implemented;

(4) An estimate of the number of the inhabitants of the state who will be directly affected;

(5) The cost to the state or citizens of the state to implement and sustain the federal reform provision; and

(6) The consequences to the state, if it does not implement or enforce that federal reform provision

(c) The reports required under subsection (a) of this section shall be accessible, at a minimum, through the Arkansas state government website.

SECTION 2. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that Congress has enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148; that the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 requires state agencies to perform acts that should be noticed to the people of this state; and that this act is immediately necessary because state agencies have already begun to perform acts that would be required to be posted on a website under this act. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

State of Arkansas
88th General Assembly
Regular Session, 2011

A Bill

HOUSE BILL 1053

By: Representatives D. Meeks, D. Altes

For An Act To Be Entitled

AN ACT TO ENSURE FREEDOM OF CHOICE IN HEALTH CARE FOR ALL ARKANSANS; TO PREVENT INVOLUNTARY ENROLLMENTS IN HEALTH CARE INSURANCE PROGRAMS; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO ENSURE FREEDOM OF CHOICE IN HEALTH CARE FOR ALL ARKANSANS; AND TO PREVENT INVOLUNTARY ENROLLMENTS IN HEALTH CARE INSURANCE PROGRAMS.

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

SECTION 1. Arkansas Code Title 23, Chapter 86, Subchapter 1 is amended to add an additional section to read as follows:

23-86-122. Health Care Freedom Act.

(a) This section shall be known and may be cited as the "Health Care Freedom Act".

(b) As used in this section:

(1)(A) "Direct payment" means payment for lawful health care services without a public or private third party paying for any portion of the service.

(B) "Direct payment" includes payments by an employer for lawful health care services for an individual;

(2) "Health care system" means a public or private entity that enrolls individuals for, manages or processes individual claims for, or manages or processes payment, in full or in part, for health care services or

health care data or health care information for its participants;

(3) "Lawful health care services" means any health-related service or treatment to the extent that the service or treatment is permitted or not prohibited by law or rule that may be provided by an individual or a business otherwise permitted to offer such services; and

(4) "Penalties or fines" means a civil or criminal penalty or fine, a tax, a salary or wage withholding or surcharge, or a fee with a similar effect that is used to punish or discourage the exercise of rights protected under this section under a law or a rule adopted by an agency established, created, or controlled by a governmental entity.

(c) A law or rule shall not compel, directly or indirectly, an individual, an employer, or a health care provider to participate in any health care system.

(d)(1) An individual or an employer may make direct payment for lawful health care services and shall not be required to pay penalties or fines for making direct payment for lawful health care services.

(2) A health care provider may accept direct payment for lawful health care services and shall not be required to pay penalties or fines for accepting direct payment from an individual or an employer for lawful health care services.

(e) Subject to reasonable and necessary rules that do not substantially limit an individual's options, the purchase or sale of health insurance in private health care systems shall not be prohibited by law or rule.

(f) This section does not affect:

(1) The health care services a health care provider or hospital is required to perform or provide;

(2) Which health care services are permitted by law; or

(3) The terms or conditions of any health care system to the extent that those terms and conditions do not have the effect of punishing an individual or an employer for making direct payment for lawful health care services or a health care provider or hospital for accepting direct payment from an individual or an employer for lawful health care services.

Cynthia Crone

From: Alice Jones
Sent: Monday, February 07, 2011 12:24 PM
To: Andrea May; Bill Lacy; Cynthia Crone; Dan Honey; Don Cordes; Drew Carpenter; Fred Stiffler; Greg Sink; Jackie Smith; James Winningham; John Morris; Lenita Blasingame; Lowell Nicholas; Mary Ann Wornock; Mel Anderson; Melissa Simpson; Nathan Culp; Pam Looney; Sandra McGrew; Sandy Currington; Steve Uhrynowycz; Terry Lucy
Subject: News Article--SB 113 (Sunday's Paper)

Publication: Arkansas Democrat-Gazette; Date:2011 Feb 06; Section:Front Section; Page Number: 1

Abortion-coverage prospects unclear

No state insurer decision yet on extra policy outside new exchanges

SARAH D. WIRE
ARKANSAS DEMOCRAT-GAZETTE

The Arkansas Constitution and federal law limit when an abortion can be paid for with public money. Women who participate in the taxpayer-subsidized insurance exchanges established under the federal health-care law will have to find and pay for separate insurance to cover the cost of an abortion or find some other way to pay for it.

Supplemental insurance for abortion does not exist in the state, according to the Arkansas Insurance Department. And two of the Arkansas insurance companies that insure the most people in the state told the Arkansas Democrat-Gazette that they have not decided whether to provide it when the insurance exchanges open.

The federal Patient Protection and Affordable Care Act requires each state by 2014 to have an insurance exchange for people who aren't insured through their employer or public programs like Medicaid and for people who work for companies with fewer than 100 employees.

States can choose whether to run the exchange themselves or have the federal government do it. The act also allows states to legislate to prohibit abortion coverage in plans offered in the exchanges.

The act prohibits federal money from being spent on abortions except in cases of rape, incest or to save the life of the woman. Amendment 68 to the Arkansas Constitution prohibits the use of state money on an abortion unless it is to save the woman's life.

The Health Insurance Exchange Planning Manager at the Insurance Department, Cindy Crone, said that while the exchange infrastructure is supposed to be self-sufficient by 2015, people below 400 percent of the federal poverty level and those on Medicaid will receive state and federal subsidies to help them pay for insurance through the exchange.

The Arkansas Legislature is considering Senate Bill 113 by Sen. Cecile Bledsoe, R- Rogers, to prohibit healthinsurance policies offered through the exchanges from covering abortion except to save the woman's life. It hit a snag Thursday when a committee recommended that it be amended to also allow abortions in cases of rape, incest and health problems.

The bill says individuals may purchase supplemental coverage for "elective abortions" for which a separate premium must be paid in a health-insurance market outside the exchange.

Some insurance companies cover abortion in pregnancies caused by rape, incest or for the mother's health as

a part of their normal coverage but none offer supplemental coverage for abortion, said Insurance Department attorney John Morris.

According to the Arkansas Department of Health, 4,580 abortions were performed in the state in 2009. The most common form of abortion, RU-486, known as the abortion pill, costs $350 to $650, according to Planned Parenthood.

SUPPLEMENTAL PLANS

Two of the three largest insurance companies in the state — Arkansas Blue Cross and Blue Shield, United-Healthcare and QualChoice — were not ready to commit to offering a separate insurance premium covering some abortions to those using the insurance exchange.

The three companies represent about 80 percent of the health-insurance market in the state, according to the Insurance Department.

A spokesman for Arkansas-based QualChoice, Cathy Crowell, said Friday that since the exchange is three years away it is too early to say if the company would be willing to offer a separate rider for abortion. The company only covers abortion when the mother's life is at stake, she said.

The company has "not made any determinations yet because there is so many issues that have to be resolved," Crowell said.

Blue Cross covers abortion ordered by a doctor and performed in a hospital, spokesman Max Heuer said.

Heuer said any company wanting to participate in the insurance exchange will have to follow state and federal restrictions. Until those restrictions are decided on, "I can't speculate on something that may or may not be applicable in the future," Heuer said.

UnitedHealthcare spokesman Tracey Lempner was not able to answer questions Friday.

FREE MARKET

Rep. Andrea Lea, R-Russellville, told the Public Health, Welfare and Labor Committee on Thursday that insurance companies may not offer a supplemental abortion rider now but will do so if a market exists for it.

"Riders on insurance are really driven by need and the people asking for them," Lea said.

Some people have raised concerns about requiring a separate insurance plan, saying it asks people to plan ahead for an abortion or a health problem.

American Civil Liberties Union of Arkansas Executive Director Rita Sklar said she does not think any insurance company will offer separate insurance to cover abortion.

"I can't imagine anybody offering it, and I can't imagine anybody buying it," Sklar said Friday. "Nobody expects an abortion, nobody expects to get raped."

An amendment sponsored by Rep. Jeff Wardlaw, D-Warren, to allow abortion for rape and incest to be covered in the taxpayer-subsidized state insurance exchanges was OK'd 11-8 by the committee.

Anti-abortion lawmakers who supported the original bill say the amended bill goes beyond the limits the state constitution sets on taxpayer funding for abortions.

Amendment 68, adopted in 1988, says "no public funds will be used to pay for any abortion, except to save the mother's life."

U.S. District Judge Bill Wilson ruled in the 1996 case Dalton v. Little Rock Family Planning Services that while the state accepts federal Medicaid funding it must adhere to Title XIX of the Social Security Act, known as the Hyde Amendment, and pay for abortions for Medicaid users in cases of rape or incest as well as to save the woman's life.

The decision applies only to when the amendment imposes different obligations than federal law.

In 1996, Gov. Mike Huckabee's administration created a private trust fund to solicit to pay providers for their services in performing abortions for Arkansas' Medicaid-eligible victims of rape or incest. The fund was rarely used over 10 years.

A 2005 Arkansas Democrat-Gazette report found no funding for an abortion claim through Medicaid had been approved by the Department of Human Services since 1990. No claim was approved from 2005 to 2008, the most recent data available Friday, according to department spokesman Julie Munsell.

Wardlaw said he doesn't think the state should interfere with how citizens spend their money.

"My intent was to publicly ensure that when people spend their private dollars on their insurance policy that we don't kill protection that they already have," Wardlaw said. "There are policies out there that offer exceptions for rape, incest and the life of the mother. I think it is important to have those exceptions if [people] already had them in those policies."

OTHER STATES

The federal health-care law allows states to prohibit abortion coverage in insurance plans offered through the insurance exchanges. According to the National Conference of State Legislatures, at least five states— Arizona, Louisiana, Mississippi, Missouri and Tennessee— have enacted legislation to restrict coverage for abortion in their insurance exchanges.

Missouri's ban prohibits insurance plans or policies that provide coverage for elective abortions from offering services within the Missouri insurance exchange. It also prohibits the exchange from offering a separate rider for elective abortions.

Missouri Insurance Department spokesman Travis Ford said companies have offered supplemental insurance specifically for abortion in the past 30 years, but he does not know their status.

The law enacted in Arizona specifies that abortion can be covered through an optional rider with an additional insurance premium.

Arizona Insurance Department spokesman Erin Klug said she is not sure if any insurance company in the state will offer a rider to cover abortion and that many insurers don't specify if they cover abortion at all.

"It's not a mandated benefit. There are insurance companies that do cover abortions and some that do not," Klug said. "I would guess it's commonly not a rider you would add."

Klug said it is difficult to determine what insurance companies will offer in 2014 when the insurance exchanges open to the public.

"This law relates specifically to what they can do in an exchange that does not exist yet," Klug said.

Every state but Alaska has received a one-year planning grant from the Center for Consumer Information and Insurance Oversight to use for determining how each state exchange will operate.

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The City Wire
Fort Smith Region
Published on *The City Wire* (http://www.thecitywire.com)

Arkansas Insurance Commissioner gives health care briefing

By *The City Wire staff*
Created *02/08/2011 - 1:48pm*

Editor's note: *Roby Brock, with our content partner Talk Business, wrote this report. He can be reached at* roby@talkbusiness.net

Arkansas Insurance Commissioner Jay Bradford on Tuesday (Feb. 4) briefed the House Public Health Committee on the health insurance exchange coming to the state in response to federal health care reform.

Bradford, who declared "I'm just your mailman," stayed away from a partisan position on the highly-controversial measure and urged Arkansas lawmakers to give his agency authority to control as much as possible at the state level.

"I'm not going to editorialize or become a part of the legislation because I don't have a vote up there [in Washington]," Bradford told committee members. "My concern about portable health care is that we put ourselves in a position to help your constituents."

"That's what I'm selling, folks. Let's take care of our people," said Bradford, a former insurance executive and former legislator who once chaired the Senate and House Public Health Committees during his tenure.

Arkansas has received three federal grants — two for $1 million apiece and a third for $200,000 — according to Bradford's morning testimony.

One of the million dollar grants is to create a health insurance exchange for private insurance companies to expand coverage in the state. When it is operational, the exchange is expected to be "self-sufficient," said Bradford, who added that he didn't anticipate it would be a "high overhead" operation.

The Insurance Department is soliciting bid requests as part of that process. The exchange will be designed to help individuals, families and small businesses shop for health insurance coverage in a way that permits an easier comparison of available insurance

plans based on price, benefits, services and quality, according to the AID web site.

A second million dollar grant will oversee the study of medical loss ratios. Under the new federal law, health insurance companies are required to spend 80-85% of their premiums on medical claims. The grant money will be used to assess and assist the agency's rate review system under changes from the new law.

A third smaller federal grant has also been received by the Insurance Department. It will pay for planning to beef up consumer protection under health care reform.

The grant monies have allowed the commission to hire 4 new employees, mostly to oversee aspects of the implementation at the state level. Bradford said when the federal money runs out, the jobs will go away.

He also told committee members that counterparts in other states that have joined in legal action to repeal health care reform are not taking any action to implement measures. He said the feds would dictate terms and conditions for those states and if the Arkansas legislature decided to do nothing.

"I would never want to be a part of that because I know we can do better," Bradford said. "Everyday, I'm acting as if it's going to happen."

Bradford explained that with questions still pending about the constitutionality of the law and the fact that all reforms are not required until 2014, the General Assembly will have a chance to implement additional measures in the 2013 regular session, if necessary.

Bradford told Talk Business after the committee hearing that he expects legislation for what's needed now to be filed later this week, weather permitting. He said he expected the bill to start in the Arkansas House for consideration, most likely in the House Insurance and Commerce Committee.

Political

Cynthia Crone

From: Alice Jones
Sent: Thursday, March 10, 2011 9:58 AM
To: Andrea May; Bill Lacy; Cynthia Crone; Dan Honey; Don Cordes; Drew Carpenter; Fred Stiffler; Greg Sink; Jackie Smith; James Winningham; John Morris; Lenita Blasingame; Lowell Nicholas; Mary Ann Wornock; Mel Anderson; Melissa Simpson; Nathan Culp; Pam Looney; Sandra McGrew; Sandy Currington; Steve Uhrynowycz; Terry Lucy
Subject: News Article--Health-law Hurdle Fails

Publication: Arkansas Democrat-Gazette; Date:2011 Mar 10; Section:Front Section; Page Number: 1

State bill for health-law hurdle fails

Panel rejects requiring legislative OK to carry out federal program

SARAH D. WIRE
ARKANSAS DEMOCRAT-GAZETTE

On a party-line vote Wednesday a Senate committee rejected a bill that would require state agencies to report on the cost of implementing the federal Patient Protection and Affordable Care Act. The bill would also prohibit agencies from implementing the law unless a specific state law allowed it.

The director of the state's Department of Human Services told the committee that the bill could have "very serious" effects for Medicaid in Arkansas.

The Committee on Public Health, Welfare and Labor voted 4-4 on a motion to recommend Senate Bill 709 by Sen. Missy Irvin, R-Mountain View. The motion was not adopted because it needed five favorable votes.

The bill would require state agencies to provide cost reports to the Legislature on the implementation of the health-care law.

"I do have serious con- cerns that there is a huge financial impact to the state of Arkansas and we don't know those costs," Irvin said. "We the legislative body and the people of Arkansas have a right to know what our state agencies are doing, how much money is being spent and how much money we will have to spend."

Committee members, along with the governor, a spokesman for the attorney general's office and state Department of Human Services officials, spoke against the part of the bill that would block implementation without legal authorization.

None objected to tracking how taxpayer money is spent to implement the law.

Human Services Director John Selig told the committee that no current Arkansas law specifically authorizes the state to make the changes to the Medicaid program required by the federal law. Several of the changes must happen within the next few months, and Selig said that under SB709 the state could not implement them without "authorizing legislation."

He said that not expanding the Medicaid program to comply with the federal law would prompt the federal government to pull its portion of Medicaid money from Arkansas.

"If we don't implement the mandated pieces, we will not have a Medicaid program," Selig said.

Irvin disagreed with the argument that the bill would affect Medicaid or the federal health-care law.

"I don't believe that my bill would have prohibited the implementation or anybody's plans to do what they wanted to do with any form of health care in the state of Arkansas," she said. "My bill simply provided an accountability to the people of this state. It provided transparency; it provided a detailed system of

implementation that would keep people informed."

The bill required state agencies to report what Arkansas law approved the implementation of any part of the federal law; how many Arkansans would be affected; and the cost and the penalty to the state for not implementing that part.

Gov. Mike Beebe and Irvin sat down Wednesday after the vote to talk about possible changes to the bill that could lead him to support it.

Beebe told reporters he agrees with the need for transparency and wants just that aspect of the bill.

"I think that to the extent that she wants transparency, I may be able to help her," Beebe said. "I want to know what this is going to cost, and I don't think there's anything wrong with the taxpayers knowing what this is going to cost."

Before the committee met, Beebe proposed amending the bill so that implementation of parts of the health-care law were not contingent on a report being filed first. Instead the agencies would have to submit a yearly report on cost, the number of people affected and the consequences of not implementing the law. The reports would be available on the state government website.

Irvin said she was not ready to make those changes.

Beebe said the changes would address fears he has about the cost that may be associated with the reporting Irvin wants. He said he is concerned the requirement to have an authorizing state law would put Medicaid funding in "jeopardy."

Beebe said the state cannot currently afford the cost of Medicaid and "really can't afford it" without federal help.

Arkansas' Medicaid program gets about $3 from the federal government for every $1 the state puts in. The program costs about $4.5 billion a year. The taxes that pay the program's costs cut into taxpayers' pocketbooks, but the program also has an economic benefit by spreading hundreds of millions of dollars through the economy through service providers.

Medicaid serves about 775,000 Arkansans. Those eligible are mostly low-income and disabled people. Medicaid has 73 programs including home-health services, visits to doctors and hospital stays.

Each state voluntarily runs its own Medicaid program, and the federal government provides the lion's share of funding. In addition to the match of dollars to state funds spent on the program, the federal government kicks in additional money for poorer states. In Arkansas, just under 80 percent of the program is federal money.

Under the broad federal health-care changes signed into law last year, adults with incomes at or below 133 percent of the poverty level will be eligible for Medicaid in 2014, giving about 250,000 more Arkansans access to the program. The federal government will pay for additional costs incurred by the increased patient population until 2017, at which point the state will be responsible for a rising share of the cost. The state burden is capped at 10 percent for the new patients in 2020.

Arkansas' Medicaid costs are already rising faster than state revenue can accommodate, and there are no brakes on those costs because the state employs the wrong payment model, according to Beebe.

While in Washington, D.C. last week, Beebe met with Kathleen Sebelius, secretary of health and human services, about developing a plan to overhaul the Medicaid payment model in Arkansas and to get an idea of how much flexibility the federal government will allow the state.

Wednesday in Arkansas' Capitol, about a dozen people protested outside Beebe's office over a letter he sent to the federal government about creating that new Medicaid payment system.

Garland County Tea Party Chairman Glenn Gallas said on the Dave Elswick radio show on Little Rock station KARN-FM 102.9/AM-920 on Tuesday that Beebe's letter to and meeting with Sebelius was an attempt to begin implementing the federal law early.

"This is Obamacare come to Arkansas. ... We're talking about O-Beebe-Care," Gallas said on the show. "This is Gov. Beebe's way of changing health care in Arkansas."

Elswick said changing Medicaid would be the "first step" to bringing the federal law to Arkansas and the committee should approve Irvin's bill to help block it.

This prompted 10 people to protest Beebe's proposal at the door of the governor's office. The committee room and hallway were full of people holding signs with statements like "we will not accept Obamacare" and "shame on Governor Beebe."

Beebe spokesman Matt DeCample said the meeting with Sebelius was only about changing Medicaid. He called connecting the meeting to Irvin's bill "just a flat-out lie."

"There's nothing secret about what we're doing. The governor has been talking about this for months and months," DeCample said. Medicaid is "already a complicated issue without piling lies on top of it."

Arkansas Democrat-Gazette/STEVE KEESEE

State Sen. Missy Irvin prepares to present her bill Wednesday in a packed meeting of the Senate Committee on Public Health, Welfare and Labor.

Alice Jones
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ArkansasOnline

Key bills up in the air as session nears end

By Michael Wickline

Sunday, March 20, 2011

LITTLE ROCK — Two weeks before its current session's scheduled end, the state Legislature has big issues still hanging.

Last week's agreement between House and Senate leaders and Gov. Mike Beebe to enact six tax-cut bills settled the question of how much state taxes will be reduced.

Pending are the state budget for fiscal 2012, what to do with this year's anticipated surplus (called the General Improvement Fund),new boundaries for the congressional districts, which proposed constitutional amendments to refer to voters, whether to ask voters to approve a diesel-fuel tax increase for highways, and what to do about implementing the federal health-care law.

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Front Section, Pages 1 on 03/20/2011

Cynthia Crone

From: Alice Jones
Sent: Monday, March 21, 2011 9:11 AM
To: Lowell Nicholas; Sandra McGrew; Bob Alexander; Cynthia Crone; Bruce Donaldson; Alice Jones; John Morris
Subject: News Article--Sunday's Dem-Gaz--Health Care

Most of you probably saw this in yesterday's paper, but just in case you didn't, I thought I would send it. The last section of the article deals with health care.

Key bills up in the air as session nears end

MICHAEL R. WICKLINE
ARKANSAS DEMOCRAT-GAZETTE

Two weeks before its current session's scheduled end, the state Legislature has big issues still hanging.

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Alternatives

Two state-employee pay-raise scenarios are being discussed behind the scenes in the 88th General Assembly as it decides how to balance the state budget for fiscal 2012 while granting some pay raises to state employees:

Scenario 1

A 1.86 percent cost of living raise for employees making $50,000 a year or less and a 1 percent COLA for employees paid more than $50,000 a year:

	Salaries of $50,000 or less	Salaries above $50,000
General Revenue	$5.5 million	$1.2 million
Matching	$1.2 million	$0.3 million
TOTAL	$6.7 million	$1.5 million
Grand total general revenue: $8.2 million		
All fund sources	$12.4 million	$2.7 million
Matching	$2.7 million	$0.6 million
TOTAL	$15.1 million	$3.3 million
Grand total all sources: $18.4 million		

Scenario 2

A 1.86 percent cost of living raise for employees making $50,000 a year or less and an increase of $930 per employee for employees paid more than $50,000 a year:

	Salaries of $50,000 or less	Salaries above $50,000
General Revenue	$5.5 million	$1.6 million
Matching	$1.2 million	$0.4 million
Total	$6.7 million	$2.0 million
Grand total general revenue: $8.7 million		
All fund sources	$12.4 million	$3.8 million
Matching	$2.7 million	$0.8 million
Total	$15.1 million	$4.6 million
Grand total all sources: $19.7 million		

SOURCE: State Department of Finance and Administration Arkansas Democrat-Gazette

Alice Jones
Communications Director
Arkansas Insurance Dept.
501-371-2835

Protecting Arkansas State Sovereignty, Civil Liberties, Personal, Water and Property Rights while Preserving the Constitution

SecureArkansasNetwork.org

HB 2138: Arkansas' Version of Obama Care

March 21, 2011 | Author admin

HB 2138, "AN ACT TO ENSURE CONTINUED LOCAL REGULATION OF INDIVIDUAL HEALTH INSURANCE COVERAGE BY ENABLING THE INSURANCE COMMISSIONER TO CONTINUE SERVING ARKANSANS; TO IMPLEMENT FEDERAL HEALTHCARE

REFORM; AND TO CREATE THE ARKANSAS HEALTH BENEFITS EXCHANGE; AND FOR OTHER PURPOSES."

Notice the subtitle: "TO ALLOW THE INSURANCE COMMISSIONER TO PROTECT ARKANSANS BY THE CONTINUED LOCAL REGULATION OF INDIVIDUAL HEALTH INSURANCE COVERAGE."

This is on the calendar for Insurance and Commerce for this Wednesday, but it could be run either on Tuesday (thru Public Health) or as late as Friday. There is also an identical bill in the Senate that hasn't been amended yet, SB 880, by Senator Malone, who is a co-sponsor on the house bill. They could ram this through in as little as three days.

The conservatives in the legislature will do everything they can to stop this bill, but it is up to the people of Arkansas to contact their state senator and representative and ask them to oppose these bills.

Please call, leave a message for your senator and representative and ask for a "NO" vote on this. Do it now. The number for the Senate switchboard is 501-682-2902 and the House switchboard is 501-682-6211.

READ THE BILL
Link to HB2138
Link to HB2138's Bill Status History

CALL YOUR LEGISLATOR
Link to the Arkansas State Legislature
House Insurance and Commerce Committee

READ THE BILL
Link to SB880
Link to SB880's Bill Status History

CALL YOUR LEGISLATOR
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Senate Public Health, Welfare and Labor Committee

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Comments are closed.

« HB1450 : Pulled Down in Committee
HB2138: Arkansas Obamacare Bill in Committee TOMORROW »

TALK BUSINESS.NET

Method Wisdom

Monday, March 21st, 2011

HEALTH CARE PROPOSALS IN THE SPOTLIGHT AND ON THE HOT SEAT

Health care reform will find itself under a glaring spotlight on Wednesday as state lawmakers review proposed changes to Medicaid and consider how to construct Arkansas law to deal with federal health care reform.

On Wednesday, a **Joint Public Health Committee** meeting will be held to discuss **Gov. Mike Beebe's** proposed changes to Medicaid. The meeting, which will be held in Room 171 after the Senate and House chambers adjourn, will include a presentation by **Arkansas Dept. of Human Services Director John Selig** and **Arkansas Medicaid Director Gene Gessow**.

Beebe is seeking a federal waiver to alter the state's Medicaid delivery system. As we've previously reported, **Beebe** wants to experiment with its Medicaid program in order to corral costs and, in theory, create better health care outcomes.

On the same day, the **House Insurance and Commerce Committee** is expected to take up **HB 2138** by **Rep. Fred Allen**, an amended bill that outlines how **Arkansas Insurance Department Director Jay Bradford** proposes the state should regulate federal health care reform.

Arkansas has been given two $1 million grants to implement different aspects of the federal law. First, the state has begun a health benefits exchange to allow for rate comparisons and regulation of the insurance industry. In **HB 2138**, many details of how the state would embark on this exchange are outlined. It also directs the exchange to be "self-sustaining" by Jan. 1, 2015 and requires an annual budget to be prepared and approved by **Bradford's** office.

A second million dollar grant will oversee the study of medical loss ratios. Under the new federal law, health insurance companies are required to spend 80-85% of their premiums on medical claims. The grant money will be used to assess and assist the agency's rate review system under changes from the new law.

A third smaller federal grant has also been received by the **Insurance Department**. It will pay for planning to beef up consumer protection under health care reform.

Insurance Commissioner Bradford has warned that if Arkansas doesn't pass state laws to govern the implementation of federal health care, U.S. regulators will set the rules.

"Let's take care of our people," **Bradford** has told state legislators in previous committee hearings on the subject.

State lawmakers opposed to federal health care reform - which is being litigated in the U.S. court system and contested in Congress - have been looking for ways to slow down or stop its enactment in Arkansas. They have also questioned the financial burdens that federal reforms may force the state to pay in the future.

On Wednesday, it's a good bet that both supporters and opponents will have lots of questions. Whether or not they get the answers they're looking for will be subject to interpretation, partisan spin and philosophical differences.

updated : 03-21-2011 20:47:26

Arkansas Times

ARKANSAS POLITICS / HEALTH CARE

The Ark. GOP's senseless health care fight

Posted by Max Brantley on Tue, Mar 22, 2011 at 8:32 AM

Here's an early look (on the jump) at Ernest Dumas' column this week. It explains the utter senselessness of the current Republican legislative fight to prevent Arkansas from operating insurance exchanges under the new federal health care law. Do Republicans really want Washington, rather than Arkansas, regulating the insurance industry in Arkansas? Do they really want our rates to be higher because rates will then have to mirror the national experience, not the state's lower costs?

Blind Republican partisanship dictates that the nonsensical answers to these questions are "yes" in the current battle, due for another round in committee Wednesday.

I don't expect any Republicans to retreat from the kill-health-care-for-all-at-any-cost campaign on account of facts or common sense. But perhaps some of the wobby Democrats might see it differently with a little education.

Read on:

By Ernest Dumas

One problem with blind partisanship is that it can lead you to betray your own principles and the well being of the people you represent.

So it is with the invigorated Republican minority in the Arkansas legislature and the national health-insurance reform law. The Republicans are intent on stymieing anything that is associated with the new federal law, which they always call "Obamacare," no matter if it is something they might otherwise support.

The part of the law they commonly attack is the part borrowed from old Republican health plans, requiring sizable employers and individuals who are uninsured to either buy health insurance or pay a tax to support health services for the uninsured. The Patient Protection and Affordable Care Act will create exchanges supervised by the federal Department of Health and Human Services, where employers and individuals starting in 2014 can shop for a private health plan that suits them and is affordable.

As a sop to conservatives, Congress gave states the option of skipping the national exchange and setting up the exchanges themselves and regulating the companies and agents, as the states do already for existing health insurance and other forms of insurance. If a state chooses not to establish its own market for individual and small-group insurance, then people in that state will purchase a plan through the national market. The premium rates and conditions and the servicing of complaints then would be handled in Washington as well.

It makes sense for a state like Arkansas to run the market instead of letting Washington to do it. As a relative low-cost state for medical care, Arkansas ought to get cheaper premiums and better conditions for employers and individuals than the national exchange likely will offer. New York might want to let the feds do it.

So Gov. Beebe, no fan of the federal law (he worries that it will impose higher Medicaid costs on the state government in about 2019), wants the state to do the job, if the law stands up in the courts, as it almost certainly will. A bill would give the state Insurance Department the authority to avoid the national exchange and create the private insurance market for Arkansas employers and individuals, set the terms and regulate the insurance companies that offer the plans and the agents who sell them.

You would think the Republicans would be clamoring to sign up. "We, not Washington, will run our business in Arkansas, thank you."

But they have blocked the bill in House Insurance and Commerce Committee, with the help of weak-kneed Democrats who worry that they might be seen as siding on something with the black president with the Asian-sounding name. I don't know, but I would guess that President Obama would be more than happy for Arkansas to let Washington manage the new health insurance market for Arkansans.

The Republicans seem to think that if the legislature does not enact the insurance-exchange bill then the federal law would never be implemented in Arkansas even if the U. S. Supreme Court declares every bit of the law constitutional. That bit of ignorance is not surprising. The Republican critics have never evinced any grasp of the law, relying instead on the talking points that were drafted before the legislation was written.

Sen. Gilbert Baker, the Republican leader, said last week: "We are not going to be implementing the federal health-care law. There is no strength in the Arkansas Legislature to enact Obamacare." He said it was debatable whether the law could be implemented in Arkansas if the legislature doesn't adopt the legislation.

Utter nonsense. The exchange bill merely exercises Arkansas's option to run the insurance market itself rather than the federal government, if and when the law is ruled constitutional.

Its defeat will accomplish only one thing: Arkansas businesses and individuals will be buying health insurance through the federal exchange supervised by the U. S. Department of Health and Human Services rather than from the locally devised and regulated market. That's what Baker and his people are achieving. Who is the champion of federal power here?

Actually, those who favored a centrally controlled health insurance system and wanted a public option (they are a good part of the polling majority opposing "Obamacare") may side with the Republicans on this one. States generally have a poor record of regulating the insurance industry although Arkansas, at least in the past several years, is an exception. The Arkansas Insurance Department collected $14 million in a year for consumers who were victimized by insurers and agents. I'm not sure the U.S. Department of Health and Human Services would police the industry any better.

The Republicans and timorous Democrats will likely kill the exchange bill, thus significantly magnifying the federal government's hand in health care delivery in Arkansas, but if you like the idea of universal health insurance this will not be a real setback. Yes, insurance may prove a trifle costlier for employers and individuals and more onerous for the industry and consumers than if the state were running the show, but this is tea-party government. We have to get used to it.

Tags: health insurance, insurance exchanges

COMMENTS (3)

I would suggest that Ernest Dumas challenge Dave Elswick to a debate on this. Or since Ernest may not be comfortable with public speaking, perhaps Max Brantley could carry the water.

Between his radio show and his facebook page, Dave Elswick has been putting pressure on the tea partiers to block this bill in committees. Dave Elswick (KARN News radio) has become the defacto leader of the Tea Party bunch, and the tea party candidates are regulars on the Dave Elswick radio show. In fact, Dave does his show from the state capital on Tuesdays (3-6pm), so he can put pressure on the tea party candidates. Why not call in and give the liberal point of view.

Posted by Viper on March 22, 2011 at 9:00 AM | Report this comment

Dave,

We're going to have to start charging you for your advertising.

Posted by Max Brantley on March 22, 2011 at 9:08 AM | Report this comment

Who the hell is Dave Elswick? Never heard of him.....

Posted by any*mouse on March 22, 2011 at 9:11 AM | Report this comment

Arkansas Times

HEALTH CARE Health care: Federal control or not?

Posted by Max Brantley on Tue, Mar 22, 2011 at 2:38 PM

The Beebe administration is preparing to try tomorrow to win Senate committee approval of legislation to enable health i necessary to implement federal health care law. Ernie Dumas has explained why defeat of the bills would be bad for Arka feds run the program, probably at a higher cost.

Now comes Death Star Jason Rapert, the insurance salesman/revivalist who'd rather just about anything than see univers In a bluntly partisan statement issued through the Senate information office (somewhat of a departure to see taxpayer in expropriated for political attack), Senator Rapert says this is "against the will of the people." Rapert has interviewed them indicate folks are ready to see how this health insurance stuff works. The Koch brothers' paid emissaries in Arkansas are out those angry old folks that turn up for Dave Elswick conspiracy seances.

A word or two for Rapert: You're so off base on this even conservative Republicans disagree. Heard of Mitch Daniels, Rep issued an executive order setting up insurance exchanges there. Nutso John Kasich, governor of Ohio? He's said an excha doesn't trust the feds to run the program. Even Scott Walker of Wisconsin is working toward an insurance exchange in Te Republican fortress? Its exchange is already in place. Oklahoma — Oklahoma! — is doing it.

Bro. Jason Rapert wants to send control to Washington. Some Tea Partyer he is.

Tags: health care reform, Jason Rapert

COMMENTS (1)

Showing **1-1** *of 1*

>>Some Tea Partyer he is.

Yes he is. In Arkansas the so-called Tea Party, which is no party at all, displays they know little about how

Mark Martin, in addition to Justin of West Fork and Sen Rapert, openly display such ignorance. Add to this list that Lt things explained to him several times about how legal challenges to the feds actually work.

Alice Jones

From: Sandy Currington on behalf of Jay Bradford

Sent: Tuesday, March 22, 2011 4:09 PM

To: Alice Jones; Amanda Rose; Ark Monroe; Audra Welcher (audra.welcher@triangleins.com); Ben Hyneman; Bill Booker; Bill Lacy; Bill Woodyard; Birdsong, Roger; Bob Jones (rjones@progressive.com); Bob Ridgeway; Bradley Phillips (bradley@phillipsmanagement.net); Brenda Haggard; Brenda Nation; Bruce Hawkins (dbhawkins@suddenlinkmail.com); Charles Snyder (Charlie_Snyder@farmersinsurance.com); Claude Holloway (ctholloway@americanlifeandannuity.com); Connie Phillips (cbphillips@usablelife.com); Courtney Crouch; Dan Honey; David Beck (dbeck@fai-pb.com); David McCullough; David Moore (david.moore@afbic.com); Deb West; Derrick Smith (dsmith@mwsgw.com); Dick Horne; Don Kee; Don Spharler (dspharler@fai-pb.com); Ed Choate; Elisabeth Wright Burak (elisabeth.burak@aradvocates.org); Eugene Phillips (ephillips@usic.com); Frank Sewall; Fred Stiffler; Gail James (gjames@bituminousinsurance.com); Herb Rule (HRULE@RoseLawFirm.com); James D. Couch (jim.couch@qualchoice.com); James Herzfeld; James Miller; Jay Bradford; Jim Thomas (jim.thomas@windstream.net); Jim Woods (jim.woods@republicgroup.com); Jody Crawford; Joe Woods (joe.woods@pciaa.net); John Bratton; John K. Harriman (jharriman@mwlaw.com); John Morris; John Travis (jtravis@guaranteeins.com); Julie Benafield Sutherland (julie_b_sutherland@uhc.com); Lawrence S. Powell Ph. D. (lspowell@ualr.edu); Lee Ann Alexander; Lee Douglass (jldouglass@arkbluecross.com); Lenita Blasingame; Linda Thompson (evp@piaar.com); Lisa Monk (lmonk@mwlaw.com); Lorrie Brouse; Lowell Nicholas; Lynda Englehart (lenglehart@mwlaw.com); Lynn Zeno; Mark Lowery; 'Mark V. Williamson'; Martha Miller (m3har13@yahoo.com); Mel Anderson; Melissa Masingill (mmasingill@ddpar.com); Mike Alderson (mikea@amcins.com); Mike Branch (mike.branch@stateauto.com); Mike Wilkinson; MikePickensLaw@gmail.com; Nick Thompson (nick.thompson@uhc.com); Paul Choate (pdchoate@sbcglobal.net); Phyllis Rogers; Ragenea Thompson (rthompson@xlhealth.com); Randi Bryant (randibryant@qualchoice.com); Raul Allegue (rallegue@travelers.com); Richard.Sims@afbic.com; Robert D. Birkmaier (BIRKMAR@nationwide.com); Robert Eichelberger (robert.eichelberger@sflic.net); Ron Doughty; russell.galbraith@farmersinsurance.com; Sandy Currington; Sara Farris (sfarris@DDPAR.com); Seleta Yearian; Steve Russell (srussell@riskservicesar.com); Steve Strange (stephenl@amcins.com); Terry Youngblood; Tom Hale (wthale@sbcglobal.net); Wayne White

Subject: FW: Legislative Alert-Immediate Action Needed

HB 2138 will be in the House Insurance & Commerce Committee tomorrow, Room 149, State Capitol.
Any help you can give us on this will be sincerely appreciated.
Jay

From: IIAA [mailto:dthomas@iiaar.org]
Sent: Tuesday, March 22, 2011 3:15 PM
To: Jay Bradford
Subject: Legislative Alert-Immediate Action Needed

Having trouble viewing this email? Click here

Independent Insurance Agent

The Trusted Choice

Legislative Alert - Immediate Action Needed

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March 22, 2011

LEGISLATIVE ALERT

Feel free to contact us at
5000 North Shore Drive
North Little Rock 72118
501-221-2444
www.iiaar.org

IMMEDIATE ACTION NEEDED

CONTACT YOUR STATE REPRESENTATIVE AND ASK THEM TO VOTE FOR HB 2138

AN ACT TO ENSURE CONTINUED LOCAL REGULATION OF INDIVIDUAL HEALTH INSURANCE COVERAGE BY ENABLING THE INSURANCE COMMISSIONER TO CONTINUE SERVING ARKANSANS; TO IMPLEMENT FEDERAL HEALTHCARE REFORM; AND TO CREATE THE ARKANSAS HEALTH BENEFITS EXCHANGE

Last year the IIAA joined most of the nation in its strong opposition to Obamacare. HOWEVER, the U.S. Congress passed "the Patient Protection and Affordable Care Act."
This federal legislation says that individual states must establish insurance programs in compliance with the federal guidelines or **THE FEDERAL GOVERNMENT WILL ESTABLISH AND CONTROL THE PROGRAM FOR THEM.**

As much as we may disagree with the federal legislation, the one thing that the Big I has always agreed on is that **THE REGULATION OF INSURANCE SHOULD BE LEFT IN CONTROL OF THE STATES** we were instrumental in getting that language included in the federal legislation.

HB 2138 is enabling legislation to allow **Arkansas Insurance Commissioner Jay Bradford** to establish and enforce the regulations establishing the Health Insurance Exchanges. **THE BILL WILL ALSO BE AMENDED TO SAY THAT IF THE SUPREME COURT RULES THE FEDERAL LEGISLATION TO BE UNCONSTITUTIONAL THEN IT WILL NEGATE THIS STATE LEGISLATION!**

This bill may be considered by the House Insurance and Committee as soon as tomorrow. Please contact your State Representative today by calling 501-682-6211 and ask them to vote:

FOR HB 2138

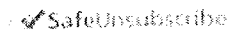
BECAUSE

- Without this enabling legislation, individual and small group health insurance will be regulated by the federal government rather than continuing to be regulated by the Arkansas Insurance Department.

- If the US Supreme Court rules Obamacare to be

unconstitutional, this legislation will go away.

Forward email



Wednesday, March 23rd, 2011

LEGISLATORS QUESTION NEED TO MOVE NOW ON HEALTH CARE LAWS

Arkansas' efforts to write state laws and regulations to implement federal health care reform was put on hold today. Members of the House Insurance and Commerce Committee delayed a vote until Friday on **HB 2138** by **Rep. Fred Allen (D-Little Rock).** The bill outlines a number of details of how the state would prepare for federal health care's enactment, assuming it survives court challenges and potential Congressional changes.

An amendment to the bill was added at the beginning of the committee meeting that says if U.S. court action rules that federal health care is not constitutional, then the state legislation goes away.

The bill has been amended 10 times to accommodate representatives' concerns.

"We are trying to hold a place in Arkansas to protect Arkansans," said **Insurance Commissioner Jay Bradford**. "We don't want to send Arkansans to Washington for help."

Bradford said last year the **Insurance Department** fielded more than 1,000 complaints from Arkansas consumers on health insurance issues.

Arkansas has been given two $1 million grants to implement different aspects of the federal law. First, the state has begun a health benefits exchange to allow for rate comparisons and regulation of the insurance industry. In **HB 2138**, many details of how the state would embark on this exchange are outlined. It also directs the exchange to be "self-sustaining" by Jan. 1, 2015 and requires an annual budget to be prepared and approved by **Bradford's** office.

A second million dollar grant will oversee the study of medical loss ratios. Under the new federal law, health insurance companies are required to spend 80-85% of their premiums on medical claims. The grant money will be used to assess and assist the agency's rate review system under changes from the new law.

A third smaller federal grant has also been received by the **Insurance Department**. It will pay for planning to beef up consumer protection under health care reform.

A number of Republican legislators on the committee asked if it was necessary to move in this session.

Insurance Department representatives said that a January 2013 deadline for having some elements of health care established requires action in this legislative session. **Bradford** warned that if Arkansas doesn't pass state laws to govern the implementation of federal health care, U.S. regulators will set the rules.

Bradford emphasized that no state money is being earmarked for federal health care reform. As he has said in previous reports, the money comes from federal grant funding.

KLRT (FOX) - Little Rock, AR
FOX 16 News at 5:00PM

± Local Market Viewership: 8,518
Local Publicity Value: $237.39per 30s
KLRT 3/23/2011 5:02:48 PM: ...are safe? log on to fox 16 dot com to vote -- or text fox16yes or fox16no to 4-5-5-4-8. your answers are in our five-30 newscast. right now -- a house committee is hearing arguments on a bill-- that would prepare the state for the federal health care overhaul. the bill would let the state **insurance commissioner** enact the structure... the state would use -- when the health care law takes effect. supporters say the bill will keep the federal government from making laws for the state -- and would help arkansans select their **insurance** provider. president obama signed health care reform into law one year ago today.

KARK (NBC) - Little Rock, AR
KARK 4 News at 5

± Local Market Viewership: 73,225
Local Publicity Value: $1,873.29per 30s
KARK 3/23/2011 5:03:44 PM: ...a plan to manage the president's health care law on the state level is getting plenty of attention at the state capitol this week. as kark 4's bob clausen tells us -- an up vote would keep it alive, while a down vote would make the health care law more difficult to navigate. the design of this is to set up a buffer -the state **insurance** commissioner- between arkansans and the federal governments health care law, to work through claims and administrative issues. without it, it would be you and the federal government dealing one on one with no help at the state level. the fed has already said pass this and we'll pay for it, it wont cost the state a dime. but if you wait thousands in available grants will dry up. if it's not in place, it opens the door for the government to hand down how it wants health care managed at the state level essentially taking control away from the state to implement policy and procedures. late this afternoon after a full day of back and forth, a house committe pushed it back until friday. but if it is passed and as the health care law rolls out over the next few years the state would be ready to set it's own plans in place. it's important to note a few states who are suing the government over the health care law have passed this legislation as a form of **insurance** over the health care law.

KAIT (ABC) - Jonesboro, AR
Region 8 News at Five

Local Market Viewership: 21,487

KAIT 3/23/2011 5:04:23 PM: ...until we know whether it succeeds. i'm stephanie elam in new york. an arkansas house committee today began work on addressing arkansas health care changes to conform to the federal health care overhaul. the **insurance** committee is considering a bill by a democratic house member that would enable the state **insurance commissioner** to implement changes so the state can meet federal mandates. republicans have promised to fight the federal changes at the state level. the state republican party says the state should wait to see how lawsuits filed by 28 other states play out before making structural changes.

KATV (ABC) - Little Rock, AR
Channel 7 News

± Local Market Viewership: 90,225
Local Publicity Value: $2,814.00per 30s
KATV 3/23/2011 6:04:03 PM: ...last week. house lawmakers voting unanimously in favor of trimming the grocery tax by a half cent, and cutting the sales tax on used cars and manufacturers' utility bills. the bills still need senate approval of house amendments.. a house committee spent a good part of the morning debating a bill that would give the state **insurance commissioner** authority to put in place a structure to implement the federal healthcare law. and the house voted in favor of raising automobile title fees to help fund the pensions for state police officers.

Cynthia Crone

From: Alice Jones
Sent: Thursday, March 24, 2011 8:49 AM
To: Andrea May; Bill Lacy; Cynthia Crone; Dan Honey; Don Cordes; Drew Carpenter; Fred Stiffler; Greg Sink; Jackie Smith; James Winningham; John Morris; Lenita Blasingame; Lowell Nicholas; Mary Ann Wornock; Mel Anderson; Melissa Simpson; Nathan Culp; Pam Looney; Sandra McGrew; Sandy Currington; Steve Uhrynowycz; Terry Lucy
Subject: News Article--Health Care Vote Delayed

Publication: Arkansas Democrat-Gazette; Date:2011 Mar 24; Section:Front Section; Page Number: 9

House panel delays vote on insurance

Bill would allow setup of health exchange required by new U.S. law

On the one-year anniversary of the federal health-care law's passage, a state House of Representatives committee delayed voting Wednesday on whether to allow the state insurance commissioner to begin the process for setting up a state health-insurance exchange.

The Insurance and Commerce Committee spent much of the day considering House Bill 2138, by Rep. Fred Allen, D-Little Rock, which would allow the commissioner to create rules as necessary to implement the federal law.

The committee is to consider the measure further at 9 a.m. Friday in Room 149 of the state Capitol.

Allen said the bill is not dead. He said it deserves more detailed discussion.

Supporters said the legislation is necessary for Arkansas to retain regulatory authority over the implementation of the Patient Protection and Affordable Care Act. Under the federal law, if Arkansas does not create an insurance exchange, the federal government will set up and control the health exchange that will operate in the state.

"We're not taking the control away, we're not letting Washington control it, but we're doing what we must do as a state to take care of our own business," committee member Rep. Reginald Murdock, D-Marianna, said.

Insurance Department attorney John Morris told the committee the U.S. Department of Health and Human Services will decide by January 2013 whether the state exchange is sufficient. That would be before the next regular state legislative session.

Rep. Mark Biviano, R-Searcy, said that legislators could make a decision about whether to authorize the planning when they meet for the 2012 fiscal session or during a special session that the governor could call.

"I believe most people would be willing to come back and debate this, if necessary," he said.

Commissioner Jay Bradford said he is concerned that if the Legislature doesn't deal with the exchange before it adjourns there will not be a time to have the exchange up to snuff before the 2013 deadline.

"That '13 date is a really hard date, you have to have everything in place," Bradford said.

Morris said the bill says no state taxpayer money will be used to set up the exchange.

Arkansas has received or is eligible for $2.5 million in federal grants to plan and set up its exchange, Bradford said. He said the governor has "warned" him that no state money will be made available.

Conservative advocacy group Secure Arkansas came out against the bill and said the state should wait to begin passing legislation to implement the federal law until it is determined whether the health-care law is constitutional.

"We're going into unknown territory here, and I feel like this needs to be killed, and we need to pause and take a break and give everybody time to properly study it," the group's chairman, Jeannie Burlsworth of Little Rock, said after the committee delayed a vote.

The health-care law has been struck down by some federal courts and upheld in others. The law is expected to eventually be taken before the U.S. Supreme Court. The U.S. House voted in January to repeal the law, but the effort was halted in the Senate last month.

The committee amended the state legislative bill so that if the federal health law is struck down the state's authorizing law will be void.

SARAH D. WIRE
ARKANSAS DEMOCRAT-GAZETTE

Alice Jones
Communications Director
Arkansas Insurance Dept.
501-371-2835

Cynthia Crone

From: Alice Jones
Sent: Thursday, March 24, 2011 1:19 PM
To: AID Staff
Subject: News Article--AID Appropriations, etc.

arkansas business.com

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Arkansas Bill Targeting Federal Health Overhaul Fails

By The Associated Press - 3/24/2011 10:20:34 AM

LITTLE ROCK - Arkansas lawmakers have rejected an attempt to block the state from spending federal money to implement the national health care overhaul program.

The Joint Budget Committee on Thursday voted down a proposal to deposit any federal money for the overhaul into a separate state account. The bill by Rep. Jason Rapert of Bigelow would have required the Legislature to approve spending any federal money for the health care law.

Rapert said the state has about 20 months before it's required to set up health insurance exchanges and that his bill would've given time to see if the overhaul withstands court challenges.

After the vote Rapert withdrew a hold he had put on the state Insurance Department's budget.

Alice Jones
Communications Director
Arkansas Insurance Dept.
501-371-2835

Ark. Times Friday Blog
03-25-11

Insurance exchange bill fails

HB 2138, the bill to set up state insurance exchanges under the federal health reform law, failed to clear committee Friday morning. The vote was 10-7, with 11 needed for approval. Could be another try next week.

Jason Tolbert reports that Democrat **Rep. Keith Ingram** was in the room, but did not vote. What's he trading for? That special language raid on the land commissioner's money for his local community college, maybe?

My further information is that another vote is up in the air. There's a great urge to get this session over before there's more mischief in other areas. If it dies at this point, the spin is simple and was articulated in questioning today by Rep. Barry Hyde: Republicans have voted to let the Obama administration oversee health exchanges in Arkansas rather than local officials. Welcome to Obamacare.

More details on the meeting from Roby Brock.

Roll call on the jump. Note that Republican Rep. Jon Woods, who'd argued for the bill's passage and who some believe was heard to vote aye on the voice vote, did not want a recorded vote for the measure. He voted no.

Friday, March 25th, 2011

STATE IMPLEMENTATION OF HEALTH CARE FAILS IN COMMITTEE

House Insurance and Commerce committee members failed to pass a bill to allow Arkansas control of federal health care reform despite amendments to mollify opponents' concerns.

On a 10-7 roll call vote, **HB 2138** by **Rep. Fred Allen (D-Little Rock)** failed. It needed 11 votes to pass the committee. The vote split along party lines with **Rep. Keith Ingram (D-West Memphis)** being the only present member to abstain. **Rep. Jonathan Barnett (R-Siloam Springs)** and **Rep. Bobby Pierce (D-Sheridan)** were not in attendance.

Ingram told **Talk Business** after the vote that he "wasn't prepared to vote on it" today.

HB 2138 outlines how Arkansas regulators would structure rate reviews and create insurance exchanges required by the new federal health care law. State officials contend they are under a Jan. 2013 deadline to show progress towards implementing aspects of the new law and they need regulatory authority meet that date. Without state control, they argue that federal administrators will set Arkansas' health exchange and rate review rules.

Arkansas officials have obtained about $2 million in federal grants for planning purposes.

Opponents of the measure have argued that the state can wait until the federal courts rule on the constitutionality of the health care law before moving further forward.

Two amendments added to the bill this week included a provision to halt all planning on the state's health care implementation if the Supreme Court declares the federal law unconstitutional. A second amendment delayed any future spending beyond current grant money until November 15, 2011 or "unless approved by all appropriate legislative bodies." It still allowed the state to pursue future federal funding.

Arkansas Insurance Commissioner Jay Bradford, who has advocated for state control, said 80% of the rules and regulations to implement health care reform have not been promulgated at the federal level. He wanted regulatory authority through the **Insurance Commission** to be able to adapt.

"We all know that there are going to be some dramatic changes at the federal level," **Bradford** said. "That's why we wanted to try to give us flexibility."

Bradford said "at least 45 states" have accepted planning grant money like Arkansas.

The bill's defeat will not stop the implementation of federal health care reform in Arkansas, **Bradford** said. He contends that the federal government will now dictate Arkansas' rules unless the bill is resurrected.

"It would appear that the will of the state legislature is for the federal government to control Arkansans' health care," he said after the meeting.

Opponents of the bill and federal health care reform in attendance at today's meeting cheered the vote.

Teresa Oelke with **Americans for Prosperity's** Arkansas chapter disagreed with **Bradford's** assessment and said there is still time for the state implementation to be considered in interim study.

"As long as the state shows progress towards an exchange - and we have time to do that - it doesn't have to be rushed through. We should look at it this summer and have input from a diverse number of people," she argued

updated : 03-25-2011 08:45:59

TB TALK BUSINESS.NET

Method Wisdom

Monday, March 28th, 2011

BILL TO REGULATE FEDERAL HEALTH CARE REFORM PASSES COMMITTEE 11-7

The only new wrinkle in the debate over state regulation of federal health care reform were the 11 yes votes in the room.

Sides for and against the new federal law overseeing health care implementation raised the same arguments they've been raising for months. Supporters want the state to control its implementation of federal health care, while opponents argued that Arkansas regulators can wait until the federal courts decide the issue's constitutionality.

HB 2138 was voted out of a packed **House Insurance and Commerce** committee room on a party line vote of 11-7. Two representatives **who did not vote on Friday** cast votes for the bill today: **Rep. Keith Ingram (D-West Memphis)** and **Rep. Bobby Pierce (D-Sheridan)**. The bill must now pass the full House and State Senate.

"This bill is in the best interest of Arkansans," said the bill's sponsor, **Rep. Fred Allen (D-Little Rock)**.

Former State Rep. Dan Greenberg argued that the committee was rushing to pass "a radical transformation" of the health care system. "It's going to transform the doctor-patient relationship," **Greenberg** said.

He also suggested that lawmakers only have to "show progress" on the issue by January 2013. "All that's required is that we have to be on track," **Greenberg** said.

Ray Handley, President of the **Arkansas Foundation for Medical Care** and a **former Hewlett Packard** executive who helped build health insurance exchanges in other states, said that the insurance exchanges that **HB 2138** would begin planning for will help consumers.

"The best analogy I've seen - they are for insurance what Travelocity is for plane tickets," **Handley** said. "If done right, this will let the consumer log on [and] shop for comparisons."

Glen Gallas, a small businessman from Hot Springs, **TEA Party** activist and former GOP Congressional candidate, said that he had a "definite and vested interest" in the issue.

"I think as legislators it's fundamentally wrong to pass a law that doesn't have details worked out," **Gallas** said. "We remember what happened to a sitting senator who voted against the citizens and voted against the will of the people on health care."

Insurance Commissioner Jay Bradford said, "All of this political drama is about the federal bill that doesn't have anything to do with this. What we have to do to take care of our people is that we have to demonstrate that we can do the planning process."

updated : 03-28-2011 11:07:54

Arkansas Times

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ARKANSAS POLITICS / HEALTH CARE **Health exchange bill clears committee**
Posted by Max Brantley on Mon, Mar 28, 2011 at 10:37 AM

Jay Bradford, the insurance commissioner, made a final run this morning before a House committee to advocate legislation to set up insurance exchanges in Arkansas to implement federal health legislation. The alternative is to let the Obama administration run the exchanges from Washington. It received a favorable vote, 11-7, drawing the minimum 11 votes required for a "do-pass" recommendation. It fell one vote short last week.

The Democratic Party was prepared to declare victory either way. It excoriated Republicans on the commitee in advance for voting last week for Obamacare, or Washington control of Arkansas health coverage decisions.

The debate was delayed to allow time for all members to be in place. The vote came after 30 minutes of the familiar arguments. Rep. Keith Ingram provided the decisive vote, after not voting Friday.

DEMOCRATIC PARTY NEWS RELEASE

n a surprising departure from their rhetoric, Arkansas Republican legislators took a step towards federal control of a mandated Arkansas health care exchange in a party line vote, Friday. The questions remains: will Republicans solidify federal control of Arkansas's pending health care exchange in the legislature this week?

"You just can't trust today's Republicans in Arkansas. Once again their actions don't match their words," Democratic Party of Arkansas spokesperson Candace Martin said. "In a party-line vote, Republicans prevented Arkansas controlling its own mandated health care exchange, instead preferring for the federal government to control the health care exchange in Arkansas. If Democrats again bring up a bill for state control of the health care exchange, will Republican legislators again vote for federal health care control in Little Rock while denouncing it back home in their districts?"

The legislation, House Bill 2138 by Rep. Fred Allen (D) failed by one vote in the House Insurance and Commerce Committee where it is expected to be brought up again.

Those voting for federal control rather than Arkansas control of the mandated health care exchange included:
Rep. John Woods (R)
Rep. Bryan King (R)
Rep. Les "Skippy" Carnine (R)
Rep. Terry Rice (R)
Rep. Mark Bivivano (R)
Bruce Westerman (R)
Allen Kerr (R)

"Will these seven Republican legislators give the federal government and Washington control of an Arkansas health care exchange, or will they reverse themselves and keep more Arkansas health care in the hands of Arkansans?" Martin asked.

The legislation in question outlines how Arkansas regulators would structure rate reviews and create insurance exchanges required under federal law. Sufficient progress in state implementation must be made by a January 2013 deadline if the state is to control the health care exchange. However, if Republicans again defeat the bill they will ensure federal administrators will set Arkansas' health exchange and rate review rules.

Tweet Share

Tags: health care reform, health exchanges, Jay Bradford, Video

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COMMENTS (11)

Sort Oldest to Newest

add a comment

Showing **1-11** *of 11*

Of course this being Arkansas I have a feeling that we would all be better off using the exchanges run from Washington.

Posted by any*mouse on March 28, 2011 at 10:49 AM | Report this comment

The only problem, any*mouse, is that we will be paying the higher national rate and not the lower one that we should be paying (or you should be paying since I do have government paid insurance-Medicare).

Posted by couldn't be better on March 28, 2011 at 11:04 AM | Report this comment

Glad to hear Reps. Pierce and Ingram were present and voted aye, giving bill 11 votes needed to pass committee.

Posted by ND '75 on March 28, 2011 at 11:18 AM | Report this comment

We should all be paying one federal rate, on a progressive income scale for single payer or tri care. Health care should be a national human right. A simple expansion of V.A, or Medicare for all.

But more Americans will die without healthcare this year, enough to fill an entire Vietnam Memorial.... so corporate profits continue unabated.

This is more of the divide and conquer highest priced ponzi health scheme in the entire world.

I would say - bend over, Arkansas, but you have been all your life.

Posted by Eureka Springs on March 28, 2011 at 11:30 AM | Report this comment

CBB, that may not be so about the rates. On becoming eligible for Medicare in '06, I bought my supplemental policy in California through AARP's insurance program since I was traveling back to California for hip replacement. California rates were cheaper than Arkansas by 30 or 40 dollars per month. I can't remember the exact amount now, but those are significant numbers for someone trying to get by on SS only as many Arkansans are.

Posted by the outlier on March 28, 2011 at 11:31 AM | Report this comment

Make that '08. I moved to Arkansas in '06. I would love to lope two years off my age, but facts are facts.

Posted by the outlier on March 28, 2011 at 11:42 AM | Report this comment

Bradford or the feds? The choice is easy. Let Bradford guide the exchanges. He understands AR.

Posted by killingmesoftly on March 28, 2011 at 12:00 PM | Report this comment

"Bradford or the feds? The choice is easy" I was with you right up to there. I wouldn't let Bradford touch anything. Corrupt former insurance exec and state Sen. Wonder how he'll find a way to take care of his insurance buddies through this?

Posted by Theodosius on March 28, 2011 at 12:36 PM | Report this comment

This was just a way for the Arkansas Democrats to get control - period.

Posted by argal on March 28, 2011 at 2:13 PM | Report this comment

You can sure tell Bryan King is faith-based. He is believing that SCOTUS is going to redeem him and his buddies so there's no need for an exchange. He has a 50-50 chance of being correct.

I'm glad Bryan raises chickens for a major corporation who is there to tell him just about very move he needs to make to raise those chickens.

Posted by eLwood on March 28, 2011 at 2:37 PM | Report this comment

So, we REALLY need a supreme court justice to retire, and not one of the left leaners. We need one more leftie up there or all this won't do much. I'm betting in the SC, this goes the repugnants way, and we are all back to square one, minus what has already been spent. I just don't want an insurance company death panel deciding where I can go and who I can see, you know?

Posted by vigilantejustice on March 28, 2011 at 3:00 PM | Report this comment

ArkansasOnline

Ready Arkansas health exchange, House panel says

Lawmakers:We do it or U.S. does

BY ALISON SIDER

Tuesday, March 29, 2011

LITTLE ROCK — A state House committee voted Monday to allow the state to start preparing a health-insurance exchange to comply with the federal healthcare law passed last year.

House Bill 2138 passed 11-7 in the Insurance and Commerce Committee, from which it failed to emerge Friday when a motion to recommend it fell one vote short.

Photo by Danny Johnston / AP

Arkansas House Speaker Robert Moore (right), talks with state Insurance Commissioner Jay Bradford before a meeting of the House Committee on Insurance and Commerce recommended a health-exchange-authorizing bill Monday.

Democrats voted in favor of the motion, and Republicans voted against it. Two Democrats who did not vote on the bill last week voted for it Monday - Rep. Keith Ingram, D-West Memphis, and Rep. Bobby Pierce, D-Sheridan.

The sponsor, Rep. Fred Allen, D-Little Rock, said he amended the bill repeatedly to try to satisfy Republicans on the committee, but none voted for it in the end.

Allen said he is still working on making sure the bill has enough votes to pass when it goes before the House later this week.

Jay Bradford, the state's insurance commissioner, said the bill allows the state to use federal money to study the best way to set up a health-insurance exchange for the state. If the state does not demonstrate progress on setting up its own exchange by January 2013, the federal government will implement and run an exchange.

"The federal government will not hesitate to step forward and regulate the health care for Arkansans," Bradford said.

The state has received $2.5 million in federal grant money to begin setting up the exchange.

Opponents said the state should move slowly and cautiously in implementing an insurance exchange or any other part of federal health-care law and suggested that the bill could be studied further and taken up during next year's fiscal session, or during a special session.

In a statement issued after the committee voted, Lt. Gov. Mark Darr said the bill was being "rushed" through the Legislature.

"I believe the state of Arkansas should not be dictated to on this issue by the federal government. That said, I also do not think that as a state, we should rush into setting up expensive bureaucracies that expand government without a careful and substantive debate from both sides," he said.

Rep. Buddy Lovell, D-Marked Tree, said it would not be possible to discuss the exchange during the fiscal session and that the governor would not be inclined to call a special session on the issue.

"I urge you to do what's right, because at this time next year, it's going to be real plain that we have voted 'no' to Arkansas taking care of the health system and 'yes' to the federal government," he said.

Some opponents said they liked the idea of insurance exchanges but not the federal health-care rules.

Rep. Mark Biviano, R-Searcy, said the state should return federal money and look into setting up a private exchange, apart from the federal government's requirements.

"We send the money back, we cancel the contract, and we go to the private sector to establish an insurance exchange. That would give us the greatest flexibility we could possibly have as a state," he said.

But Ingram said it made more sense to work with the federal government.

"It didn't work real good in '57 when we defied the federal government," he said, referring to state resistance to desegregation at Little Rock's Central High School.

Ingram said conversations he had had with people over the weekend about what the exchange would do, as well as about other states that are moving forward with their plans, made him comfortable voting for the bill.

States are supposed to have exchanges up and running by January 2014. Speaking for the bill, Ray Hanley of the Arkansas Foundation for Medical Care compared health-insurance exchanges to websites such as Travelocity for purchasing airline tickets.

The exchange would allow individuals and small companies to shop for insurance plans online. The plans would be rated according to criteria set out by the U.S. Department of Health and Human Services.

"It would really help small business owners because they're going to be able to put their people in an exchange with thousands of people there. And the law of numbers should spread the cost," Bradford said.

Sen. Percy Malone, D-Arkadelphia, sponsored a similar measure in the Senate but said he will work with the House bill when it comes to the Senate and does not currently plan to move forward with his version.

The health-care law has been struck down by some federal courts and upheld in others. The law is expected to eventually be taken before the U.S. Supreme Court. The U.S. House voted in January to repeal the law, but the effort was halted in the Senate last month.

Two amendments added to Allen's bill last week would tie implementation of the bill to the Supreme Court's actions. One amendment delays spending federal money to begin setting up the exchange until Nov. 15 or until the court rules that the health-care law is constitutional. Another amendment would make the entire bill void if the Supreme Court overturns the health-care law.

Front Section, Pages 4 on 03/29/2011

3.29.11

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This article was published today at 5:52 a.m.

The Party of No emerges in Arkansas

Posted by Max Brantley on Tue, Mar 29, 2011 at 1:24 PM

The **Insurance Department appropriation** was defeated in the House today. It was approved 53-41, with 75 votes needed. Haven't seen roll call yet, but I presume it's close to strict party line, with Republicans voting to shut down an agency of state government rather than let it plan to implement federal law. As I've mentioned before, Republican redoubts from Indiana to Utah have proceeded with this planning, but the Tea Party in Arkansas would rather the Obama administration run our health programs.

Will Republicans shut an agency down? We'll see.

Tuesday, March 29th, 2011

INSURANCE DEPT. FUNDING DEFEAT THREATENS MORE THAN HEALTH CARE REFORM

Political wrangling over health care reform could throw a monkey wrench in legislators' plans to go home on Friday or it could shut down a state agency aimed at protecting insurance consumers.

On Tuesday, the Arkansas House voted down **HB 1226**, the appropriation bill for the **Arkansas Insurance Department**, by a 53-41 margin after Republican lawmakers said that the measure contained funding for "Obamacare." The bill needed a supermajority of 75 votes to pass.

The state's receipt of $2 million in federal grant funding to implement health care insurance exchanges and medical ratio reviews has come under attack during this session by GOP legislators who campaigned against the issue last fall. They cite continued lack of public support for federal health care reform.

But state regulators and many Democrats, including **Gov. Mike Beebe**, have stressed that Arkansas is bound to implement federal reforms until Congress or the U.S. Supreme Court reverse the law.

State Insurance Commissioner Jay Bradford barely passed a state regulatory bill dealing with health care implementation out of a House committee on Monday after multiple tries and numerous amendments. The bill, **HB 2138** by **Rep. Fred Allen (D-Little Rock)**, lays out some details of how Arkansas would plan for the insurance exchanges using federal grant money. An amendment to the bill would cease state planning functions of health care reform if the federal bill is ruled unconstitutional.

Opponents of health care reform have argued that the state can wait until the courts rule or Congress finishes its business before meeting a January 2013 progress deadline. Supporters say the state can't wait until a later time without risking federal regulators taking over the process.

Today's **Insurance Department** appropriation defeat could threaten that effort, but it also could jeopardize other agency functions, including licensing of agents, criminal investigations and consumer complaint protections. Additionally, tens of millions of dollars of insurance claims related to workers comp and public school insurance claims that flow through the agency would not have authority to be paid.

Insurance Department officials had no comment on today's vote. However, later in the day department officials distributed a "fact sheet" with data about the agency's operations. Officials contend that if the **Insurance Department** is not funded:

- $154.3 million in premium taxes from insurance agencies would go uncollected
- General revenue would suffer a loss of $98.4 million
- Police and Firemen's Pension funds would lose approximately $55.9 million
- 72,159 producers and title agents would not be licensed
- 6,183 agencies would not be licensed
- 1,544 insurance companies would not be licensed

The department said that **Arkansas Farm Bureau, Arkansas Blue Cross and Blue Shield, QualChoice** and 68 other domestic insurance companies would have to cease operations in state, noting that "thousands of Arkansans are employed by these companies."

House leaders on both sides of the aisle and **Beebe** administration officials tell **Talk Business** that they are not sure how they will resolve the impasse at this juncture. One high-ranking budget leader complained that the vote against the department funding bill "violated the spirit" of the tax cut-budget agreement hammered out by the House, Senate and **Gov. Mike Beebe**. Lawmakers have a self-imposed deadline of Friday, April 1 to complete their legislative business.

updated : 03-29-2011 17:28:03

Alice Jones

From: Wilkinson, Jeremy [jwilkins@naic.org]
Sent: Tuesday, March 29, 2011 9:28 AM
To: Alice Jones
Subject: FW: New MMS Alert - NAIC

Hi Alice, we missed you in Austin. Here's a load of TV hits.

Media Alert From TVEyes Media Monitoring Suite

(click thumbnail to play)

Insurance commissioner on KATV (ABC) - Little Rock, AR
03/28/2011 05:03:26 PM
Channel 7 News Live at 5 (News)

...state could wait a year and still meet federal deadlines, but insurance commissioner jay bradford says the state needs to have the framework in place by 2013. also at the capitol. ...

(click thumbnail to play)

Insurance commissioner on KLRT (FOX) - Little Rock, AR
03/28/2011 05:31:13 PM
FOX 16 News at 5:30PM (News)

...votes needed to get it to the house. while the insurance commissioner tried to convince the commitee. jay bradford says: ""all this political drama is about the ...


(click thumbnail to play)

Insurance commissioner on KARK (NBC) - Little Rock, AR
03/28/2011 06:04:46 PM
KARK 4 News at 6 (News)

...favor of it, when it needed 11. state insurance commissioner jay bradford testified in front of the committee, telling them this was not about being for or against the ...

(click thumbnail to play)

State insurance regulators on WTOP2-DC (Radio) - Washington, D.C.
03/28/2011 09:21:24 PM

...and then we have people dying all the were key regulators including representatives of state insurance regulators which is a very new component to the way the federal government is interacting with the financial system insurance is generally been a state issue talk to and be supported by the ...

(click thumbnail to play)

Insurance commissioner on KLRT (FOX) - Little Rock, AR
03/28/2011 10:06:45 PM
Fox 16 News at 10PM (News)

...votes needed to get it to the house. while the insurance commissioner tried to convince the commitee. jay bradford says: ""all this political drama is about the ...

Insurance commissioner on KATV (ABC) - Little Rock, AR
03/28/2011 10:11:16 PM
Channel 7 News Nightside (News)

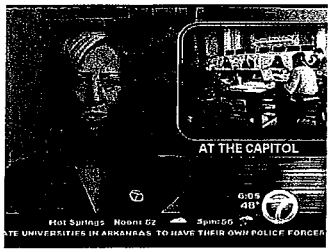
...exchange and still meet federal deadlines. insurance commissioner jay bradford claims the state needs to have the framework in place by 2013. the house will vote on the bill next. ...

(click thumbnail to play)

Insurance commissioner on KATV (ABC) - Little Rock, AR
03/29/2011 05:05:36 AM
Daybreak -- Early (Talk Show)

...exchange and still meet federal deadlines. insurance commissioner jay bradford claims the state needs to have the framework in place by 2013. the house will vote on the bill next. ...

(click thumbnail to play)



Insurance commissioner on KATV (ABC) - Little Rock, AR
03/29/2011 06:05:15 AM
Daybreak (Talk Show)

...exchange and still meet federal deadlines. insurance commissioner jay bradford claims the state needs to have the framework in place by 2013. the house will vote on the bill next. ...

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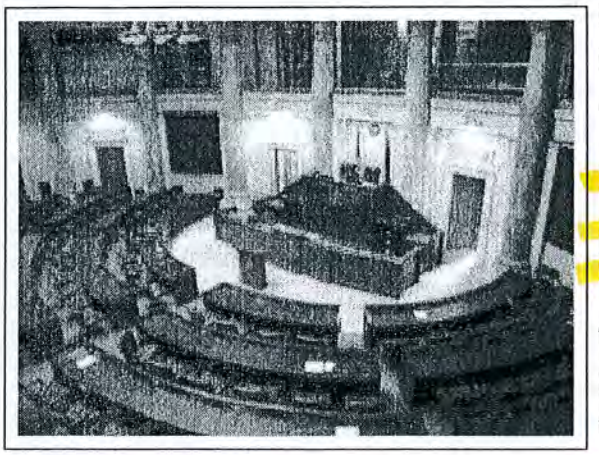
Republicans Still Blocking Insurance Agency Budget

3·30·11

15 hours 3 minutes ago By Kelly MacNeil



Republican lawmakers say they don't really want to shut down the state Insurance Department. But Governor Beebe says that's just what will happen if they keep blocking the agency's budget.

For two days, a minority of Republicans in the House has blocked the department's budget because it contains a provision to plan for implementation of federal health care overhaul.

The bill has been unable to get the supermajority it needs to advance. Governor Beebe now says he expects the legislative session to end without an Insurance Department budget.

Republicans, meanwhile, say Democrats are being stubborn in refusing to remove the provision to start planning a health insurance exchange.

Insurance Commissioner Jay Bradford says the state couldn't function without an Insurance Department, and Republicans are making a mistake.

"All this stuff about budgets, that certainly has an element of politics in it," said Bradford. "And I don't think the people want us to play politics with their safety and their wellbeing."

House minority leader John Burris says Republicans have been backed into a corner by Democrats who want to rush the program through.

"They are willing to risk the Insurance Department for the implementation of health care reform. We asked that that be separated out," said Burris.

Governor Beebe says a shutdown of the state Insurance Department would be catastrophic, but Burris says he's confident that won't actually happen.

Alice Jones

From: Alice Jones

Sent: Wednesday, March 30, 2011 8:43 AM

To: Andrea May; Bill Lacy; Cindy Crone; Dan Honey; Don Cordes; Drew Carpenter; Fred Stiffler; Greg Sink; Jackie Smith; James Winningham; John Morris; Lenita Blasingame; Lowell Nicholas; Mary Ann Wornock; Mel Anderson; Melissa Simpson; Nathan Culp; Pam Looney; Sandra McGrew; Sandy Currington; Steve Uhrynowycz; Terry Lucy

Subject: News Article--AID Budget Bill Voted Down

Insurers' regulator gets 'no' on funds

Health exchange sinks it in House

BY ALISON SIDER , MICHAEL WICKLINE , SARAH D. WIRE

LITTLE ROCK — The state House of Representatives defeated the $72.6 million appropriation for the state Insurance Department on Tuesday because it contained $1 million to help the department prepare a health-insurance exchange that would operate under the federal health-care law if it survives court challenges.

The bill got 53 favorable votes in the 99-member House with 41 against, but 95 percent of appropriation bills need a three fourths majority - or 75 favorable votes - to pass, and this one, House Bill 1226, is one of those.

Rep. Stephen Meeks,R-Greenbrier, called for the defeat of the bill, telling the House there was $1 million in it for insurance exchanges and "the folks here in Arkansas said unequivocally that they are against this program. My constituents back home have told me they would rather see the Insurance Department shut down than have this money go forward."

2010 Legislature

Without the appropriation, the department will have no budget. With no budget, there will be no department. With no department, the 170 or so employees of the department will be out of work.

The department's operating money doesn't come from state general revenue such as sales and income taxes but from fees and assessments imposed on the entities it regulates. Without the department, those entities would have a freer hand to engage in the kind of consumer fraud the department was created to prevent and prosecute and policyholders would be more vulnerable to unscrupulous practices.

Without the department, companies such as Blue Cross and Blue Shield could no longer legally operate in the state because they would not be licensed to and thousands of their employees would lose their jobs, said House Budget Chairman Kathy Webb, D-Little Rock.

The department collects more than $250 million in fees and taxes annually, answers about 17,000 Medicaid questions a year, helps with the police and firefighter pension funds, and controls insurance for the state's fleet of cars, schools and other property, she said.

Meeks said he isn't sure whether the situation can be resolved before the Legislature recesses Friday.

"It's a very fluid situation right now, and we'll just have to take a wait-and-see approach," he said.

Earlier in the current legislative session, new conservative lawmakers blocked appropriation bills that contained spending increases. Eventually they reached a compromise in which Democrats

agreed to tax cuts and Republicans stopped holding up appropriations.

But Webb said the insurance-exchange money will probably stay in HB1226.

"At this point, I do not think that [removing the money] would be likely, but I did not think we would anticipate any blocking of any appropriation when we agreed to the tax cuts," she said. "But if that's the way they want to proceed then we'll have to see what happens."

Gov. Mike Beebe said he's standing by Webb.

"You've got to draw a line, I guess," Beebe said. "She probably feels like she has to draw a line, and she's done a really, really good job, and I certainly wouldn't second-guess her."

The House Insurance and Commerce Committee voted Monday to allow the state to start preparing a health-insurance exchange. House Bill 2138 passed 11-7 after it failed to emerge Friday when a motion to recommend it fell one vote short.

If the state does not demonstrate progress on setting up its own exchange by January 2013, the federal government will implement and run an exchange for the state, provided the federal law remains.

Webb said she didn't understand why the House failed to pass the department's appropriation bill. "It seems counter to the opinions they've expressed all session about wanting us to have control over health care," she said.

Beebe spokesman Matt DeCample said cutting off the department's funds will do more than stop the insurance exchange. The department also regulates insurance companies, resolves insurance complaints and helps seniors work with Medicaid, he said.

"If they want to go home and leave Arkansans unprotected and insurance companies without regulation, that is their prerogative," DeCample said.

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sandra.mcgrew@arkansas.gov

Transcript Log In

KARK (NBC) - Little Rock, AR
KARK 4 News at 10

+ Local Market Viewership: 57,012
Local Publicity Value: $4,484.48per 30s
KARK 3/30/2011 10:03:57 PM: ...shy of the three-fourths supermajority needed for passage. today.. supporters were only five votes short. republicans still voting against it don't want to see the agency shut down... but they dont' want to support the line-item in the department's budget that funds the implementation of federal health care for the state. **insurance commissioner** jay bradford says this could be devestating for the state of arkansas. ""it would really be a tsunami for small business people. so it's really just not an option not to have an **insurance** department."" if the **insurance** department shuts down... that could mean that all **insurance** business in the state does as well. also at the capitol --

Transcript Log In

KARK (NBC) - Little Rock, AR
KARK 4 News at 5

+ Local Market Viewership: 73,225
Local Publicity Value: $1,873.29per 30s
KARK 3/30/2011 5:02:01 PM: ...be a factor...but that amendment failed. representative burris did ultimately vote to pass the department's budget...16 other people who yesterday voted against it....also changed their minds. still, the bill fell five votes short of the 75 it needed. now, **insurance commissioner** jay bradford says, unless there's another vote....the **insurance** department would have to shut down by the start of the next fiscal year...and so would the services the state agency provides. july first, all those protections would go away and it would be an economic disaster for out state. now, it's not very likely the legislature will shut down the **insurance** department... we're hearing there still could be a compromise..but the clock is ticking....there are only two days left. still on the plate too....approving the budget...that's on tap for tomorrow.

Alice Jones

From: Wilkinson, Jeremy [jwilkins@naic.org]
Sent: Thursday, March 31, 2011 8:42 AM
To: Alice Jones
Subject: FW: New MMS Alert - NAIC

Media Alert From TVEyes Media Monitoring Suite

Insurance commissioner on KARK (NBC) - Little Rock, AR
03/30/2011 05:02:01 PM
KARK 4 News at 5 (News)

...short of the 75 it needed. now, insurance commissioner jay bradford says, unless there's another vote....the insurance department would have to shut down by the ...

(click thumbnail to play)

Insurance commissioner on KARK (NBC) - Little Rock, AR
03/30/2011 06:01:42 PM
KARK 4 News at 6 (News)

...still not enough...so what happens now? insurance commissioner jay bradford says this could be devestating for the state of arkansas. it would really be a ...

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Insurance commissioner on KARK (NBC) - Little Rock, AR
03/30/2011 10:03:57 PM
KARK 4 News at 10 (News)

...federal health care for the state. insurance commissioner jay bradford says this could be devestating for the state of arkansas. ""it would really be a ...

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Thursday, March 31st, 2011

HOW ABOUT AN INSURANCE DEPARTMENT COMPROMISE?

The scuttlebutt this morning is that lawmakers have been negotiating all night on a resolution to their stalemate on the **Insurance Department** budget, which has been tripped up by a minority of House members opposed to $1 million in funding for federal health care reform.

This morning, several lawmakers say that an agreement hasn't been reached.

But a possible path to victory for all sides could exist.

HB 2138 by **Rep. Fred Allen (D-Little Rock)** is the controversial measure that would give **Insurance Commissioner Jay Bradford** regulatory authority to move forward with the state's implementation of federal health care reform.

Allen thinks he has the votes to squeak the measure through the House, but he's not sure about the Senate.

Of course, **HB 1226**, the **Insurance Department** budget bill, which has the $1 million federal grant to plan for the health insurance exchanges, can't muster 75 votes in the House for passage and a three-fourths majority in the Senate is dubious.

Two GOP legislators opposed to the exchanges and the money in the agency's budget said their votes to allow **Insurance Department** funding could be swayed if **Allen's** bill is sent to interim study. With the votes for passage questionable, that may be the fate of **Allen's** bill anyway.

By sending **HB 2138** to interim study in exchange for funding **HB 1226**, all sides could claim victory. The GOP members against health care reform get to slow down the pace of health care reform and are provided a forum for monitoring the Insurance Commissioner's progress towards a 2013 deadline.

The **Insurance Department** gets the money to at least pay for overhead for the interim study and is allowed to continue planning for state implementation of the federal law albeit at a less aggressive pace than it might want. Of course, **Allen's** bill was amended to abort the state's efforts if federal health care reform is struck down or repealed.

- Arkansas News - http://arkansasnews.com -

House ends health reform deadlock; Senate OKs scholarship bill

Posted By Idelavan On March 31, 2011 @ 1:37 pm In Arkansas News Bureau, News, Top Stories | No Comments

By John Lyon and Rob Moritz
Arkansas News Bureau

LITTLE ROCK — A deadlock that threatened a major disruption in state government ended today when, in a compromise agreement, the House passed the state Insurance Department's budget and sent a health care reform implementation bill to interim study.

Also today, the Senate passed legislation to lower state lottery-funded scholarship amounts for new recipients this fall.

In an 83-7 vote, the House approved House Bill 1226, an appropriation bill containing the Insurance Department's budget for the next fiscal year. The bill had failed in three previous votes when some Republican members voted against it because it contained $1 million for implementation of the health insurance exchange mandated by the federal health care overhaul.

The money for the exchange comes from a federal grant the state already has received.

After today's vote on the Insurance Department's budget, Rep. Fred Allen, D-Little Rock, requested that HB 2138, his bill to authorize the Insurance Department to implement the exchange, be studied by lawmakers after the regular session.

Gov. Mike Beebe had warned that the stalemate in the House could leave the Insurance Department without a budget, threatening jobs, insurance coverage and more. Beebe spokesman Matt DeCample said today the governor was glad to see the department's budget approved but still believed Allen's bill was a good bill.

"It would have kept more control over the insurance exchange here in Arkansas rather than in the hands of the federal government," DeCample said.

House Minority Leader John Burris, R-Harrison, said House members reached a good compromise. Allen's bill could be passed during next year's fiscal session, he said.

"We can study it, we can talk about it, we can still make progress so that if the federal health care reform is not declared unconstitutional or it's not overturned by a future Congress in a year, then we'll be ready," he said.

State Insurance Commissioner Jay Bradford said that if Arkansas — and not the federal government — is to operate the exchange, it has to have it ready to go by January 2103.

He said work on the exchange was "derailed to a degree" by the referral of Allen's bill to interim study, but insurance officials will keep working with the Legislature.

"It's really important for Arkansas that this ends up being regulated here in the state," he said "It's our choice. (The federal Department of) Health and Human Services is quite willing to take it. I'm not willing as an advocate for the public to give that away, and neither is the governor. I think that eventually the Legislature will see it that way."

The Insurance Department's budget is to be considered in the Senate on Friday.

The House also reconsidered Senate Bill 303 by Sen. Johnny Key, R-Mountain Home, which had failed Wednesday, and passed it in a 73-16 vote.

The bill would amend the School Choice Act of 2004 to remove a ban on a student transferring to a district in which the student does not live if the percentage of students of his or her race in that district makes up a

larger percentage of enrollment than in the student's home district. It would not allow such a transfer if the transfer would conflict with a federal desegregation court order.

The bill goes to the governor, who has said he will sign it.

In the Senate, HB 1947, the bill to reduce lottery scholarship amounts, passed on a 28-2 vote. It goes to the governor.

The bill by Rep. Mark Perry, D-Jacksonville, would lower the amounts of lottery scholarships by 10 percent — from $5,000 to $4,500 annually for new recipients attending a four-year institution and from $2,500 to $2,250 for those attending two-year schools.

The Legislative Lottery Oversight Committee recommended the changes because the number of scholarship recipients this school year, the lottery's first, exceeded expectations, as did the percentage of recipients choosing to attend a four-year school.

Both the Senate and the House today also approved identical versions of the Revenue Stabilization Act, which priorities state spending for the fiscal year that begins July 1. Each bill will be considered by the other legislative body on Friday.

Sen. Gilbert Baker, R-Conway, co-chairman of the Joint Budget Committee, said later that he was pleased with the RSA.

"I think folks just knew where we were with the budget, how tight things were," he said.

Rep. Bryan King, R-Green Forest, spoke against the RSA bill in the House. He complained that House members had little time to study it and said it contained too much growth in state jobs, salaries and benefits at a time when the median household income in Arkansas has gone down.

"What I see in the real world, and what's happened to me at different times, is that when your income goes down in your business and in your personal income, you have to do what? You have to do more for less," he said.

Rep. Tracy Pennartz, D-Little Rock, said she and other members of the Joint Budget Committee spent countless hours working on the budget and looking for ways to improve it. She said the committee has made "good advances in addressing the reduction of our employee force in state government."

House members approved the bill on a 78-15 vote.

Both the Senate and House today also approved identical versions of the bill that details how the Legislature and Gov. Mike Beebe will split about $50 million for projects from state funds, also known as the General Improvement Fund.

Each bill will be considered by the other body on Friday.

Under the proposal, Beebe receives $40 million, of which about $25 million will go into the Governor's Quick Action Fund for economic development needs, and the Legislature will split $10 million.

Friday is scheduled to be the last day of regular business for the session, which is to adjourn formally on April 27.

The Senate is to elect its next president pro tem on Friday. Sens. Larry Teague, D-Nashville, and Robert Thompson, D-Paragould, are seeking the post.

Alice Jones

From: Alice Jones

Sent: Thursday, March 31, 2011 8:43 AM

To: Andrea May; Bill Lacy; Cindy Crone; Dan Honey; Don Cordes; Drew Carpenter; Fred Stiffler; Greg Sink; Jackie Smith; James Winningham; John Morris; Lenita Blasingame; Lowell Nicholas; Mary Ann Wornock; Mel Anderson; Melissa Simpson; Nathan Culp; Pam Looney; Sandra McGrew; Sandy Currington; Steve Uhrynowycz; Terry Lucy

Subject: News Article--Insurance Dept.

Publication: Arkansas Democrat-Gazette; Date:2011 Mar 31; Section:Front Section; Page Number: 1

Impasse runs risk of idling state agency

Sides are dug in over funds for an insurance exchange

SARAH D. WIRE, MICHAEL R. WICKLINE AND ALISON SIDER
ARKANSAS DEMOCRAT-GAZETTE

After a second day of wrangling, some House Republicans, the budget committee chairman and the governor all refused to budge in their standoff over a stalled Insurance Department appropriation, an impasse that could shut the agency down.

The state House of Representatives twice defeated the bill Wednesday over some lawmakers' concerns that $1 million of the $72.6 million appropriation will be used to create a health-insurance exchange.

The first vote was 70-23, the second 70-19. It also failed to pass Tuesday when it got fewer favorable votes, 53. Ninety-five percent of appropriation bills need a three-fourths majority — or 75 favorable votes — to pass, and this one, House Bill 1226, is one of those.

House Republican Leader John Burris, R-Harrison, tried unsuccessfully to remove the money for the insurance exchange from the bill before the House voted.

"We're in a very complicated situation," Burris said, because of several new lawmakers' "principle problems with the bill."

If lawmakers do not approve the bill, the department will receive no funding and insurance companies across the state will have to stop operating, the budget committee chairman said.

Gov. Mike Beebe, who has been in Arkansas politics for three decades, called the House actions "tragic" and "pretty catastrophic."

"I've been here a long time. I've never seen them leave here without passing an agency's budget. It's a different day, it's a different world now," Beebe said. "They've about convinced me they're going to go home without the budget, so we'll see it for the first time."

Beebe said the money for the insurance exchange is important because it allows the state to have control over the fund rather than the federal government. Some Republicans said they would approve the bill without the health-exchange money.

Beebe said he hasn't considered whether to call a special session if lawmakers refuse to approve the appropriation.

"If they wouldn't pass it in a regular session, why would they pass it in a special session? I don't think anything would change," Beebe said.

The House chairman of the budget committee, Rep. Kathy Webb, D-Little Rock, said it is a "critical budget."

Webb said that not passing it means: Companies such as Blue Cross and Blue

Shield could no longer legally operate in the state because they would not be licensed; the state would collect $250 million less in fees and taxes annually; about 17,000 Medicaid questions would go unanswered.

Burris told the House that the Republicans who voted against the bill are not trying to shut down the department.

"We realize at a certain point this appropriation has to pass," Burris said. "When there's 25 people with principled beliefs it's difficult to get an appropriation passed."

The second time the bill was brought up for consideration, Burris spoke in favor of passing it.

"I wish the bill was different, but it's not," Burris said. "I think it's time to move on and appropriate the money for this agency."

But some new lawmakers said they aren't willing to budge.

"The people in my district told me to come down and block this bill in any way that I could," Rep. Nate Bell, RMena, said.

Several Democrats said objections to the bill should have been raised earlier in the session. The bill was filed Jan. 25.

"There's three days left in the session," Rep. Buddy Lovell, D- Marked Tree, said.

Burris said some lawmakers feel as if the state is moving too quickly in implementing the insurance exchange, when there is a chance that the U.S. Supreme Court might strike the federal health-care law down or Congress might repeal it.

It "doesn't have to be implemented today," Burris said. "There is just some legit concern that we're prematurely spending millions of dollars."

The health-care law has been struck down by some federal courts and upheld in others. The law is expected to eventually be taken before the U.S. Supreme Court. The U.S. House voted in January to repeal the law, but the effort was halted in the Senate last month.

SETTING UP THE EXCHANGE

The House delayed a vote Wednesday on a separate bill that would allow the state to start preparing a health-insurance exchange to comply with the federal health-care law.

House Bill 2138 by Rep. Fred Allen, D-Little Rock, allows the state to use federal money to study the best way to set up a health-insurance exchange for the state. If the state does not demonstrate progress on setting up its own exchange by January 2013, the federal government will implement and run an exchange.

In total the state has received $2.5 million in federal grant money to begin setting up the exchange.

A health-insurance exchange is supposed to be an online pool where people can shop for insurance plans at one location. The exchange is expected to differ in each state.

Alice Jones
Communications Director
Arkansas Insurance Dept.
501-371-2835

Media Monitoring Suite

Transcript

KTHV (CBS) - Little Rock, AR
THV This Morning

+ National Viewership: 5,205,649
National Publicity Value $806,875.60 per 30s
Local Market Viewership: 49,895
Local Publicity Value: $1,588.18 per 30s

KTHV 4/1/2011 6:06:58 AM: ...the fourth congressional district, which has customarily covered south arkansas. the bill passed thursday despite pleas from fayetteville legislators to not cut the city out of the third district. a senate committee rejected an identical bill earlier thursday. and democrats and republicans in the house have reached a compromise and approved the budget for the state insurance department. the bill has been held up since tuesday because of g-o-p objections to creation of a framework for the health insurance component of the federal health overhaul. a recent report targeting arkansas bridges as structurally deficient has transportation officials questioning the findings. ""transportation for america"" says the bridges with ""poor"" ratings could become dangerous without repair. there are currently around 12-thousand bridges in the state. eight of the most heavily traveled are in pulaski county. transportation officials say a majority of the report is false. - ""any bridge that's not safe we're not going to allow people to travel on it. whether it's a roadway or a bridge, if it's open it's completely safe."" bollick says construction on the new broadway bridge is set to begin by the end of this year. watch out for road work on i-630 this weekend. crews will shut down the westbound ramp coming from baptist hospital at six tonight. they re-open it by six monday morning. you'll have to hit 630 east bound and take the john barrow exit to get back on the interstate westbound. another u of a fraternity finds itself the target of a lawsuit. a former student is suing the kappa sigma fraternity - saying he was beaten by members during a float trip in missouri last september. the lawsuit filed by tony pardew says members of the fraternity broke his jaw and left him on the shore of elk river. he says he was a transfer student who members mistook for a pledge and beat him after he didn't give them a cigarette as pledges are required. stay with us-- after the break we've got more from tom and alyse live at ida burns elementary in conway.stick around! it's friday-- and that means mike the auto guy is...

Alice Jones

From: Wilkinson, Jeremy [jwilkins@naic.org]
Sent: Friday, April 01, 2011 8:42 AM
To: Alice Jones
Subject: FW: New MMS Alert - Insurance department - KATV (ABC)

What a week! . . .

Media Alert From TVEyes Media Monitoring Suite

(click thumbnail to play)

Insurance department on KATV (ABC) - Little Rock, AR
04/01/2011 08:27:19 AM
Good Morning America (News, Talk Show)

...lawmakers on be aisle have come to an agreement on a budget for the state insurance department. since tuesday because of republican objections to the creation of the framework for the state's health care exchange. legislators against the bill argued the state could wait another year to create the exchange and still meet federal ! deadlines. with a possible government...

Alice Jones

From: Alice Jones
Sent: Friday, April 01, 2011 8:45 AM
To: Andrea May; Bill Lacy; Cindy Crone; Dan Honey; Don Cordes; Drew Carpenter; Fred Stiffler; Greg Sink; Jackie Smith; James Winningham; John Morris; Lenita Blasingame; Lowell Nicholas; Mary Ann Wornock; Mel Anderson; Melissa Simpson; Nathan Culp; Pam Looney; Sandra McGrew; Sandy Currington; Steve Uhrynowycz; Terry Lucy
Subject: News Article--Dept. Budget

Publication: Arkansas Democrat-Gazette; Date:2011 Apr 01; Section:Front Section; Page Number: 1

$72.6 million insurance bill clears House

With session's end today, raft of measures advance

SARAH D. WIRE, MICHAEL R. WICKLINE AND ALISON SIDER
ARKANSAS DEMOCRAT-GAZETTE

Thanks to a compromise, the state House of Representatives overwhelmingly approved a $72.6 million appropriation for the state Insurance Department on Thursday, ending a stalemate that had threatened the future of the department and of insurance in Arkansas.

A Republican minority of the House had been able to block the legislation because the state constitution requires a 75 percent majority, which is 75 votes in the 100-seat House, to pass most appropriation bills, including this one.

House Bill 1226 failed on Tuesday with 53 favorable votes and twice on Wednesday with 70 favorable votes each time before sailing through the House on Thursday 83-7 and going on to the Senate for further consideration in a session scheduled to finish today, its 82nd day.

The GOP opposition was focused on $1 million of the $72.6 million. That $1 million would finance the department's work to plan and develop a state health insurance exchange under the federal health-care law. That $1 million remains in the bill.

The compromise involves another bill, HB2138, by Rep. Fred Allen, D-Little Rock, which would authorize the department to set up that exchange. Allen withdrew his bill from further consideration in the current legislative session and instead let the Legislature study the health exchange matter in the coming months. Allen said he did not have enough support to pass the bill and said it was not a compromise. It would take only 51 votes in the House to pass Allen's bill.

Gov. Mike Beebe had warned that if the appropriation bill did not pass, the department could have shut down, ending the operation of insurance companies in the state, a point echoed by some Democratic members of the House and a point of worry among insured Arkansans.

"Obviously, I'm very pleased that they passed it. ... It's about time," Beebe said. "I was worried they would go home without a budget."

Some House Republicans said the agreement slows implementing the federal healthcare law in Arkansas, but Democrats said the action handed control of the health exchange to the federal government.

Stopping Allen's bill does not stop the department from planning for the health exchange, just from actually creating it, according to a department spokesman.

The Legislature's approval still will be needed before the exchange is implemented. If the state does not demonstrate progress on setting up its own

exchange by January 2013, the federal government will implement and run one for the state, provided the federal law continues in effect.

Beebe said the state missed out by not passing Allen's bill and that the resulting situation strengthens the federal government's presence in the state.

"[Allen's bill] let Arkansas do it instead of Washington," Beebe said. "They should have passed that if you want Arkansas to be in charge."

He said studying the health exchange probably won't meet the federal requirements and the health exchange will be controlled federally.

A health-insurance exchange is supposed to be an online pool where people can shop for insurance plans at one location. The exchange is expected to differ in each state.

Alice Jones
Communications Director
Arkansas Insurance Dept.
501-371-2835

Media Monitoring Suite

Transcript

KATV (ABC) - Little Rock, AR
Good Morning Arkansas

+ Local Market Viewership: 27,603
Local Publicity Value: $906.53 per 30s

KATV 4/1/2011 9:49:42 AM: ...canned black beans 1 red bell pepper 1 green bell pepper 1 small red onion salt & pepper to taste 8 ounces of hendrickson's vinaigrette salad dressing lawmakers on both sides of the aisle have come to an agreement on a budget for the state insurance department. the bill had been in limbo since tuesday because of republican objections to the creation of the framework for the state's health care exchange. legislators against the bill argued the state could wait another year to create the exchange and still meet federal deadlines. with a possible government shutdown a little over a week away, white house and congressional negotiators are working to come up with a compromise spending bill. although the republican-led house voted last month to cut more than $60- billion dollars from this year's budget, house speaker john boehner has agreed to discuss a compromise in the $33 billion range. without action by congress, the money black bean & corn salad sugar water 1 corn cob per person 2 cups of dried black beans or canned black beans 1 red bell pepper 1 green bell pepper 1 small red onion salt & pepper to taste 8 ounces of hendrickson's vinaigrette salad dressing...

Friday, April 1st, 2011

GOVERNOR DISCUSSES END OF SESSION ATMOSPHERE

Gov. Mike Beebe met with reporters at the end of the week on what was hoped would be the last day of the **88th General Assembly**.

Legislators have been unable to conclude Congressional redistricting, a once a decade process to redraw federal House of Representative lines.

Beebe said he has been surprised by the partisan bickering in the House since the numbers of Democrats and Republicans in the Senate and House are about even.

The Governor said he is eyeing two bills for possible veto, but declined to say which ones they were. He said he wanted to talk to the bills' sponsors to see if a veto could be avoided.

On the contentious Congressional redistricting issue, **Beebe** said he would not get involved in negotiations, calling it "the legislature's purview."

He did say that he would sign into law any Congressional map passed by the legislature as long as his attorneys viewed it as constitutional. When asked if the controversial "Fayetteville to the Fourth" map was constitutional, **Beebe** said he was told it was, citing the contiguous nature of the counties and the population variances of less than one percent.

On another volatile session issue, **Beebe** said he would not use his executive power to move forward with creating health insurance exchanges. A measure to start the planning necessary to move that aspect of federal health care reform was parked in interim study.

Beebe said he would not go that route and would respect the "will of the legislature."

updated : 04-01-2011 11:39:02

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Leadership gone wrong

By Jerry Jackson/ Not Quite A Native
The Sun-Times
Posted Mar 31, 2011 @ 04:36 PM

Heber Springs, Ark. — About a month ago I penned a column as to why our Governor and our Attorney General failed to join 28 other states in an attempt to repeal Obamacare. As reported the Governor's office told me directly the reason they didn't is that it wouldn't make any difference on the outcome of the lawsuit.

Subsequent developments indicate the response from the Governor's right-hand man might have been not only misleading but purposefully false. After hobnobbing with Kathleen Sebelius, one of the honchos behind Obamacare and President Obama himself, i comes out Governor Beebe has now decided to make Arkansas the model experiment for implementing Obamacare. Please note this information was not released by the Governor's office but by reporters digging into meetings between our Governor and Obama.

Is our Governor representing the people of Arkansas? That question comes to the forefront because on a percentage basis more Arkansans voted against Obama than any other state.

Carrying this point down to the local level only 26 percent of Cleburne County voters voted for Obama. How do you square all this with the obligation of our Governor to represent the views of Arkansans?

In researching the Obamacare mess I have read another important point that could drastically affect us as fellow Arkansans.

If this law suit against Obamacare is successful, it is quite possible the courts could rule this would affect only the 28 states bringing this litigation. That would certainly debunk the Governor's position that joining or not joining in this litigation would make no difference.

To quote Debbie Pelley in the Arkansas Dem-Gaz, "Many of us knew Beebe was dancing to Obama's tune on every issue, but the general public, even most Republicans, did not realize the degree of the dance. Now that his plan for Obamacare in Arkansas is revealed, everyone will know how liberal Beebe really is."

The good news, as of this writing, Beebe's grand surrender and promotion of the Obamacare plan has been stalled. It was voted dow in committee. Will it come up again or will Beebe try to implement it through executive order? Let's hope not.

Let's review for a moment why so many of us are so strongly opposed to this nightmarish program. The overwhelming reason is "we can't afford it". Any claim that this will break even over any period of time is absolute nonsense. Even the not so non-bias Congressional Budget Office (CBO) admits Obamacare will cost us in the trillions.

Governor Beebe authored a column in the March 23rd issue of The Sun Times. His generalized statements indicate he wants to be a leader in health care.

That motive is noble but he is completely off-base when he thinks this leadership should encompass Obama's plans. The Governor says he is talking to U.S. Health and Human Services Secretary Kathleen Sebelius because he says whatever we do must have federal approval. In my opinion that is an erroneous approach.

First of all if the courts follow the judge's ruling in Florida, Obamacare will be dead and we won't need federal approval on every step we take in Arkansas.

Secondly and probably most important, our Governor and other leaders in Arkansas should be taking steps to take us away from the federal government's domination of health care.

One example would be to promote health savings accounts. This brings an incentive to the individual to help control his own medica costs. Another important step would be work with the insurance companies to offer bare bones coverage with large deductibles. It is ridiculous to have states mandate that insurance companies cover such items as physical therapy, psychiatric care and dental care.

There should be interstate competition and not create a climate where one or two large insurance companies have a monopoly on the market.

Some of these concepts could be integrated with existing Medicare coverage. When I first became eligible for Medicare, I shopped around trying to buy a health insurance policy with a high deductible and not enter the Medicare program.
I couldn't do it. The federal government will not allow insurance companies to sell medical insurance to those over 65 years of age. Further, those over 65 can no longer purchase health savings accounts.
To solve our health care crises and the looming Medicare crises there must be some innovation and experimentation, not the same old stuff about raising the Social Security eligibility age or increasing taxes on wages and earned income.
In summary the current solution prescribed by Obamacare misses the mark. As Ed Lacy, Administrator for Baptist Health Heber Springs, so patiently explains – there are three legs to health care: 1) cost, 2) quality of care, 3) accessibility. It is impossible to have the utmost in all three. When doctors are scarce and you add 40 million people to the free health care roles, cost and quality will suffer greatly.

(Jerry Jackson of Heber Springs writes his "conservative viewpoint" column each Wednesday)

arkansas business.com

Insurance Provides Great Theater at State Capitol

By Mark Carter - 4/4/2011

Not since former Little Rock lawyer Aaron Jones went hopping out of his Chenal Circle home in the dead of night has insurance in Arkansas provided as much theater as it did last week in the General Assembly.

As lawmakers scurried like worker bees to wrap up the session's work, the House Insurance Committee provided the opening act, passing Rep. Fred Allen's House Bill 2138. It would begin the process of implementing a state health insurance exchange as mandated by the health care reform act passed by Congress last year.

The Little Rock Democrat succeeded on the third try in advancing the bill - by one vote - to the House floor, where it eventually was sent for interim study, to be brought up in the 2012 fiscal session.

The bill's deferment to interim study was part of a compromise reached last week between Democrats, who want to begin work on implementing a state exchange now lest the federal government do it for them, and Republicans, who want no part of "Obamacare" and prefer to wait out the judicial system, where federal health care reform is being challenged as unconstitutional.

After failing to keep the bill from advancing out of committee, Republicans last week turned to a different strategy, one made available to them just this year - keeping the Arkansas Insurance Department's $72.6 million budget bill on the House floor. That budget includes $1 million provided by the federal government to implement the exchange system. But any budget bill requires a three-fourths majority to pass, and thanks to November's anti-incumbent, Republican wave, the GOP now holds 45 seats in the House.

Democrats were able to muster 70 House votes last week, but twice the bill failed to reach the 75-vote threshold, forcing a compromise.

One local observer called it a game of high-risk chicken, and indeed it was. Failure to pass the state Insurance Department's budget, Gov. Mike Beebe said, would have effectively shut down the insurance industry in the state.

Allen's exchange bill almost didn't make it out of House Insurance, much less advance on the House floor. Its third try last week succeeded only because of the presence of Rep. Keith Ingram, D-West Memphis, absent for previous votes. His nod gave the bill its necessary 11th vote to clear the 20-member committee, made up of 12 Democrats and eight Republicans. Before a charged, standing-room-only crowd that had reporters taking refuge in phone booths, committee votes were cast down party lines each time. The final tally was 11-7 in favor, with one Republican and one Democrat not present.

Rep. Buddy Lovell, D-Marked Tree, argued that not passing the bill would open the door for the federal government to implement the system itself after a 2014 deadline.

"If we vote no, then we've turned it over to the federal government," he said.

Rep. Mark Biviano, R-Searcy, argued for a private exchange alternative and said lawmakers still had time to look at better options.

Nice to Have Options

Senate Bill 305, which would authorize the bonding out of the state's $346 million unemployment benefits debt, was on its way to Beebe's desk late last week.

The measure, by Sen. Jeremy Hutchinson, R-Little Rock, would enable Beebe to put the issue on the ballot for voters to decide whether or not to bond out the two-year-old debt owed the federal government.

Potentially, Hutchinson says, bonding the debt could save the state as much as $25 million in interest charges.

Meanwhile, another measure aimed at stemming the ongoing unemployment debt will become law. SB 593, supported by the Arkansas State Chamber of Commerce and sponsored by Sen. Jonathan Dismang, R-Beebe, passed the Senate unanimously last week and awaited Beebe's signature.

It would freeze unemployment benefits effective July 1, 2012, reduce the number of benefit weeks from 26 to 25, and raise qualification requirements.

Clipboards Holstered

The debate over appraisals and broker's price opinions is over, at least until next session.

Senate Bill 720 was signed into law, enabling the Arkansas Real Estate Commission to regulate the use of BPOs. It was sponsored by Sen. Jonathan Dismang, R-Beebe.

Appraisers opposed the bill for fear that it would open a crawl space, of sorts, for BPOs to be used by real estate professionals in place of full, blown appraisals in some situations.

And More Interim Study

The practice of hiring employees not authorized to work in the U.S. is not likely to stop anytime soon. But one bill that aimed to address the problem in the construction industry has failed to advance out of its second straight session.

Rep. Jim Nickels' HB 1013 would have authorized the state Contractors Licensing Board to police the practice of hiring illegal workers, empowering the board to revoke or suspend the licenses of contractors found to have knowingly done so.

It passed the House but stalled for weeks in Senate committee, where it wasn't defeated, but eventually pulled and last week recommended for interim study.

Nickels, a Sherwood Democrat, amended the bill several times for industry groups, including one that dropped a requirement that contractors use the federal E-Verify system to check the status of workers, and another that exempted contractors' liability when a subcontractor hired an illegal worker.

Nickels even suggested that work on state office buildings had been performed by illegal workers, another issue scheduled to be taken up by the Senate State Agencies Committee later this spring.

Bill opponents cited the burden they believed it would place on the CLB, and their belief that what amounts to immigration enforcement is a federal issue.

Full-Time Homey

Biviano's HB 2160 regarding the definition of full-time employee was headed to Beebe late last week.

The Searcy Republican's bill would amend the definition of "new full-time employee," as it applies to business incentives, to include employees who work from home.

The bill passed the House with 88 votes and was approved in Senate committee.

No Traction

John Walker's House bill to afford union status on all public employees made committee agenda, but that's where its journey appears to have ended.

HB 2145 by the Little Rock Democrat last week idled on the House State Agencies Agenda; the committee was not expected to hear it.

Not surprisingly, it drew staunch opposition from the State Chamber.

Carefree Highways

The 2012 ballot will include a half-cent sales tax proposal to fund road improvements in Arkansas, thanks to a Senate vote.

The half-cent, 10-year tax would create a bond to pay for road improvements and create a four-lane highway system throughout the state.

The proposal is part of House Speaker Robert Moore's $2.8 billion highway improvement package. Thanks to legislation already in place, Beebe has the option of placing a 5-cent diesel tax hike on the 2012 ballot as well. It would fund another highway bond program.

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

State of Arkansas *As Engrossed: H2/1/11 H2/2/11*
88th General Assembly **A Bill**
Regular Session, 2011 SENATE BILL 113

By: Senators Bledsoe, G. Baker, J. Dismang, Files, Hendren, Holland, J. Hutchinson, Irvin, G. Jeffress, J. Key, M. Lamoureux, B. Pritchard, Rapert, B. Sample, J. Taylor, Whitaker, E. Williams, D. Wyatt
By: Representatives Lea, T. Bradford, D. Altes, Baird, Bell, Benedict, Biviano, Branscum, J. Burris, Carnine, Carter, Clemmer, Collins, Collins-Smith, Dale, Deffenbaugh, J. Dickinson, English, Eubanks, Garner, Gillam, Hammer, Harris, Hickerson, Hobbs, Hopper, D. Hutchinson, Johnston, Kerr, King, S. Malone, Mauch, Mayberry, D. Meeks, S. Meeks, Rice, Sanders, Shepherd, Slinkard, G. Smith, Stubblefield, Westerman, Woods, *Barnett, Hubbard*

For An Act To Be Entitled

AN ACT TO PROHIBIT HEALTH INSURANCE EXCHANGE POLICIES FROM OFFERING COVERAGE FOR ABORTIONS EXCEPT THROUGH A SEPARATE RIDER; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO PROHIBIT HEALTH INSURANCE EXCHANGE POLICIES FROM OFFERING COVERAGE FOR ABORTIONS EXCEPT THROUGH A SEPARATE RIDER.

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

SECTION 1. Arkansas Code Title 23, Chapter 79, Subchapter 1 is amended to add an additional section to read as follows:

23-79-155. Health insurance exchange coverage of abortions in the state health insurance exchange prohibited.

(a) As used in this section:

(1) "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of

the child after live birth, or to remove a dead unborn child who died as the result of natural causes, accidental trauma, or a criminal assault on the pregnant woman or her unborn child; and

(2)(A) "Elective abortion" means an abortion for any reason other than to prevent the death of the mother upon whom the abortion is performed.

(B) However, an abortion shall not be deemed an elective abortion to prevent the death of the mother based on a claim or diagnosis that without the abortion the mother will engage in conduct that will result in her death.

(b) The General Assembly finds that:

(1) Federal funding for insurance plans that cover abortions is prohibited by the Hyde Amendment and the Federal Employee Health Benefits Program;

(2) Congress enacted and the president signed into law the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148;

(3) In the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, states are explicitly permitted to pass laws prohibiting qualified health plans offered through a health insurance exchange in their state from offering abortion coverage;

(4) It is the longstanding policy of this state that the unborn child is a human being from the time of conception and is, therefore, a legal person for purposes of the unborn child's right to life and is entitled to the right to life from conception under the laws and constitution of this state; and

(5) It is the longstanding policy of this state to protect the right to life of the unborn child from conception by prohibiting abortion, and that policy is impermissible only because of the decisions of the United States Supreme Court. Therefore, if those decisions of the United States Supreme Court are ever reversed or modified or the United States Constitution is amended to allow protection of the unborn then the existing policy of this state to prohibit abortions shall be enforced.

(c)(1) In accordance with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, all qualified health plans offered through a health insurance exchange established in this state shall not include elective abortion coverage.

(2) This section does not prevent an individual from purchasing optional supplemental coverage for elective abortions for which a separate premium must be paid in the health insurance market outside of the state health insurance exchange as provided in subsection (d) of this section.

(d) An issuer of any health plan that offers optional supplemental abortion coverage offered in the health insurance market outside of the state health insurance exchange shall:

(1)(A) Calculate the premium for optional supplemental abortion coverage so that the premium fully covers the estimated cost of an elective abortion for an individual who enrolls for elective abortion coverage.

(B)(i) The insurer shall determine the premium required under subdivision (d)(1)(A) of this section on an average actuarial basis.

(ii)(a) In making the calculation required under subdivision (d)(1)(B)(i) of this section, the issuer shall not take into account any cost reduction in a qualified health plan offered through a health insurance exchange established in this state estimated to result from the provision of abortion coverage that the insurer offers and that covers the individual who enrolls for elective abortion coverage.

(b) As used in subdivision (d)(1)(B)(ii)(a) of this section, cost reduction estimated to result from provision of abortion coverage includes estimated cost reduction in prenatal care, delivery, and postnatal care;

(2) Require that if an enrollee is enrolling in a health insurance plan that provides coverage other than optional supplemental abortion coverage, at the same time as the enrollee is enrolling, the enrollee shall sign at the same time three (3) separate signatures:

(A) A signature for coverage for optional supplemental abortion coverage;

(B) A signature for coverage other than for optional supplemental abortion coverage; and

(C) A signature acknowledging that the enrollee has received the cost of the separate premium; and

(3)(A) Provide at the time of enrollment a notice to enrollees that specifically states the cost of the separate premium for coverage of elective abortions.

(B) The notice required under subdivision (d)(3)(A) of

this section shall be distinct and apart from the notice of the cost of the premium for the portion of the health plan that provides coverage other than optional supplemental abortion coverage.

(e) An issuer of a health plan providing coverage offered through a health insurance exchange established in this state that provides coverage other than elective abortion coverage shall not discount or reduce the premium for the coverage on the basis that an enrollee has elective abortion coverage.

(f) This section does not apply in circumstances in which federal law preempts state health insurance regulation.

/s/Bledsoe

Department of Information Systems
Arkansas. A State of Technology.

Project Charter

Project Name: **Single Sign On – HIE Initiative** ***Date:*** **3-2-2011**

Project Number: **8ML ZA5A** ***Agency:*** **Department of Information Services**

Modification Dates: **3-2--2011** ***Prepared by:*** **John Gholson**

Vision Statement

The **Arkansas Health Information Exchange (HIE) Project** is the collaborative effort of public and private stakeholders to plan a technology-based, secure Health Information Exchange system that will improve the health care experience for patients, providers and insurers. The **Health Information Exchange (HIE)** is the ability to electronically connect and exchange information between individuals (patients, physicians, pharmacists) and providers (hospitals, doctor's offices, clinics). HIE is technology that allows real-time information to be shared in a secure and confidential manner so that treatment can be rendered when and where it is needed. The technology that allows the information to flow back and forth in a secure and confidential manner is the "exchange" at work.

An important aspect of this secure and confidential exchange and the most efficient way that users will access the HIE is through a Single Sign On method. Single Sign On (SSO) (also known as Enterprise Single Sign On or "ESSO") is the ability for a user to enter an id and password one time in order to logon to multiple applications within an enterprise. To that end, the State Security Office in the Department of Information Systems will work to procure and deploy a viable Single Sign On solution in support of the Arkansas HIE project.

Project Objectives

Agency Goals	Project Objectives
Workforce Excellence	By creating an enterprise Single Sign-On solution service, major applications requiring authenticated access will be able to be supported by the State of Arkansas.
Customer Service Excellence	The State will procure and deploy a SSO solution for the HIE initiative that meets their needs in a practical and actionable way.
Operational Excellence	The implementation of a SSO solution will be designed to ensure our customers will have a secure and confidential way to access their required applications.

Project Scope

The scope of this project will be broken down into 2 phases. Phase 1 will include tasks to clearly define the project scope, schedule, and align resources; define the product requirements; and select a product and/or vendor. Phase 2 will include all activities relating to building, testing, and deploying the Single Sign-On solution for the HIE Project.

Project Assumptions

The project plan timeline and phased approach assumes that the State of Arkansas staff and information are made available in a timely manner.
This project plan includes the selection of a vendor solution and will follow the existing State of Arkansas procurement process and procedures.
The selected solution will allow for cost recovery in alignment with OMB A-87.

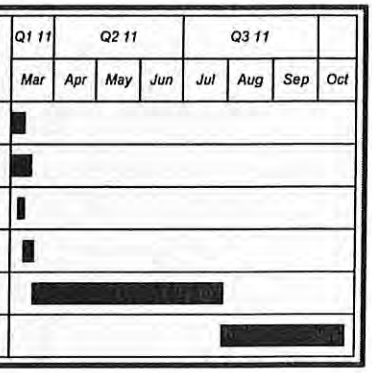
Project Budget

There will be a financial requirement in order to procure a SSO solution. The cost will be determined as part of the procurement process.
Estimated resource requirement based on preliminary work effort is **500 hours**.
This requirement will be refined once the WBS and Project Schedule are developed as part of the scope of work. The project SOW should be completed by the project team within 30 days of the signing of the project charter.

Project Schedule

Scheduled completion date of phase 1 of this project is estimated to be **29 July 2011**. The project schedule will be refined and updated once the project SOW is completed by the project team within 30 of signing the project charter. Below is a high level Gantt chart with proposed Milestone completion timeframes.

ID	Milestone Name	Start	Finish	Duration
1	Charter Signed	3/2/2011	3/11/2011	8d
2	Complete Schedule	3/2/2011	3/16/2011	11d
3	Complete Objectives Analysis	3/7/2011	3/11/2011	5d
4	Define Project Requirements	3/11/2011	3/18/2011	6d
5	Select SSO Solution	3/18/2011	7/29/2011	96d
6	Deploy SSO Solution (Estimated)	7/29/2011	10/20/2011	60d



Project Risks

Risk Area	Assessment	Impact	Mitigation
Leadership, Support and Buy-In	High	Project requires involvement and support from all stakeholders for a Single Sign-On solution.	Dedicated project management effort and including primary stakeholders in the selection process.
Staffing	Medium	Success of project depends on ability to staff with credible experience in the technical areas.	Use of 3rd party vendors to build internal expertise; staffing assessment at each project review.
Cost	High	Financial resources are not sufficient to realize HIT SSO objectives	Develop a total life cycle cost estimate during concept validation as part of the milestone decision.
Schedule	Medium	Objective is to deploy a Single Sign On solution in support of the HIE initiative by July 2011.	A phased approach will allow the team to implement a working solution in a timely manner.
Technology	Medium	The SSO technology is relatively new to the State of Arkansas. Personnel resources are not knowledgeable in backend systems, authentication, and single sign-on solutions	Once a vendor solution is chosen, the knowledge transfer and support will be planned and implemented.

Project Authority

- ***Authorization***

  The DIS CSO and Executive Sponsor, Kym Patterson and the project steering committee (further explained below) will be expected to make decisions regarding this project. If events occur where the strategic plan for the project could be impacted or if there are changes in personnel or funding needed, the events will be presented to the DIS CSO and project steering committee for review and approval.

Project Roles and Responsibilities

This is the initial project charter, therefore only the high level roles are identified. The project team is expected to refine these roles as needed as well as add the core technical team roles to the final project charter. This project is expected to utilize a core team which will consist of the Sponsor, PM, 1 Procurement SME, 1 Security SME, and various Steering Committee team members.

- ***Executive Sponsor***

  DIS CSO Kym Patterson is considered the executive sponsor for this initiative. Her involvement and responsibilities are outlined below:

  - Signs off on initial business case and all updates/changes to the business case
  - Approves the project charter and scope
  - Provides clarification of DIS project priorities as they impact process and systems development
  - Champions the project process and its outcomes with visible expression of support both within and outside the organization
  - Provides for the funding of the project
  - Is integral to connecting with customers and setting expectation externally
  - Provides change leadership
  - Help address roadblocks, remove obstacles or other constraints
  - Will provide resources or ensure that resources are available to carry out the project to its completion
  - Quickly resolve policy issues referred by the steering committee

- ***Project Manager***

  Paul Waits has been assigned as the project/program manager for this initiative. The assigned PM will perform the following activities as they relate to project completion:

  - Act as central point of contact for all project activities
  - Develop realistic work estimates, financial budgets and timelines
  - Manages development and maintenance of Business Case
  - Create and maintain project plans
  - Measure progress toward goals and revise project plans and work tasks accordingly
  - Manage the day-to-day activities of the project
  - Manage scope, time, cost and quality
  - Define requirements and plan deliverables and tasks required to meet requirements
  - Make timely decisions to assure efficient project progress
  - Review project deliverables and secure appropriate signoffs
  - Access resources as required and manage resource issues in a timely fashion
  - Manage issue resolution and execute change request process and escalation as appropriate
  - Facilitate team lead discussion and status reporting
  - Provide weekly and monthly status reports to project team, sponsors and steering committee

- Facilitate communication and discussions with advisors and extended team, if applicable
- Provide direction to project team leads and members and empower them to fulfill their responsibilities
- Work with third party vendors to define timeline and deliverables and manage them to meet the deadlines and develop quality deliverables
- Assure integration and communication across project team and third party vendors
- Take initiative to proactively identify and mitigate project risks

- ***Steering Committee***

Due to the high visibility and strategic importance of this initiative, it is recommended that we utilize a project steering committee. This committee will be chosen by the project sponsor and executive leadership team and will be disbanded when the project is deemed complete. The following are the responsibilities of this committee:

- Approves updates/changes to the business case
- Review and approve project charter and appropriations request
- Communicate project charter and emphasize management sponsorship and commitment to the project's success to the organization
- Set and manage expectations of and communicate to top management
- Set standards by which project success will be measured
- Provide input and support the company's long term goals and vision
- Set priorities and approve scope for the program
- Analyze and make timely decisions on changes proposed by the project team
- Commit the required resources to the project
- Make timely decisions to resolve escalated issues
- Review and approve project work and progress through key milestones
- Take initiative to proactively identify and mitigate project risks
- Set appropriate financial and professional incentives for key roles on the project
- Hold ultimate responsibility for the success of the project

- ***Technical Managers***

  - Responsible for cross-functional integration with both functional teams and with technical teams.
  - Ensure inter-dependencies in project plan reflect the nature and sequence of tasks on project.
  - Execute to master project plan and report completion of tasks against master project plan.
  - Ensure team's adherence to naming conventions, documentation standards, and project charter.
  - Leads efforts of internal and external consulting resources on the functional teams.
  - Alert Project Manger(s) on project risks resulting from resource shortages, inappropriate skill sets (internal and consulting) that may impair system quality or project schedule.
  - Identify and resolve project issues.
  - Identify post-implementation support requirements.
  - Mentor/guide/advise project teams (technical and functional) with new dimension functionality and best practices.
  - Identify gaps in skills/training and communicate these with project manager. Escalate issue to leadership team as appropriate.
  - Ensure appropriate feedback to the project team members from various meetings and communicate as appropriate.
  - Monitor development effort for all enhancements, interfaces, conversions, reports, and forms. Assist technical team as needed to gain understanding of business and performance needs, and design points.
  - Coordinate testing and documentation resource requirements from business with resource needs identified in the project plan.
  - Review test plans (functional and technical) to ensure integrity and quality of production system.
  - Ensure that the DIS and customer targets and objectives are met by the system.

Critical Success Factors

In support of the vision and project objectives, the SSO project should have the following attributes in order to be deemed successful:

- Document the current authentication architecture and processes at a high level
- Document a future state authentication and single sign-on architecture that supports the requirements of the business strategy
- Select viable vendor solutions and perform a weighted analysis of vendor solutions to ensure project objectives are met
- Procure selected solution
- Deploy selected solution
- Market and communicate the new solution in order to increase adoption

Signatures

The signatures of the people below relay an understanding in the purpose and content of this document by those signing it. By signing this document you agree to this as the formal Charter statement to begin work on the project described within.

Name/Title	Signature	Date
Kym Patterson State CSO		
Paul Waits, PMP/Project Mgr		
Scott Utley, State Enterprise Architect		
Brooks Evans, DHS CSO		
Britton Kerr, AID CSO		
Bruce Donaldson, HBE		
Chad Harvison, OHIT CSO		
Bob Sanders, INA		
Victor Sterling, DHS/DMS Data Security Administrator		
Cynthia Crone, HBE Planning/Project Director		
James Winningham, AID Deputy Commissioner for Info Svs		