State of Arkansas

96th General Assembly **A Bill** SENATE BILL___

Regular Session, 2027

By: Joshua P. Irby

For An Act To Be Entitled

TO ESTABLISH COMPARABLE HEALTH INSURANCE MARKET TIERS TO ENHANCE CONSUMER PRICE COMPETITION AND TRANSPARENCY; TO REQUIRE THE OFFERING OF THREE (3) STANDARDIZED BENEFIT TIERS WITH IDENTICAL CORE COVERAGE WITHIN EACH TIER; TO PRESERVE PREMIUM COMPETITION AND NETWORK FREEDOM; TO EXERCISE THE STATE'S RESERVED AUTHORITY TO REGULATE INSURANCE; AND FOR OTHER PURPOSES.

Subtitle

TO REQUIRE THREE (3) COMPARABLE HEALTH INSURANCE TIERS TO IMPROVE PRICE DISCOVERY, STRENGTHEN MARKET COMPETITION, AND PROTECT CONSUMER CHOICE WHILE PRESERVING INSURER FREEDOM TO COMPETE ON PRICE, SERVICE, AND NETWORK DESIGN.

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

SECTION 1. TITLE.

This act shall be known and may be cited as the "Arkansas Health Insurance Market Transparency and Consumer Choice Act."

SECTION 2. FINDINGS, PURPOSE, AND AUTHORITY.

(a) The General Assembly finds that:

1. The regulation of insurance is reserved to the states under the federal McCarran–Ferguson Act;
2. The State of Arkansas retains sovereign authority under the Arkansas Constitution and

the Tenth Amendment to regulate the structure and offering of insurance products within its jurisdiction;

3. Transparent and comparable insurance markets strengthen consumer choice and enhance price competition;
4. When health insurance products differ in core benefit design, meaningful price comparison becomes difficult, limiting competitive market forces;
5. Standardized benefit structures improve price discovery while preserving competition in premiums, network composition, service quality, and administrative efficiency;
6. Competition functions most effectively when consumers can compare substantially similar products on price and value;
7. This act does not authorize the state to set premiums, control reimbursement rates, operate an insurance plan, or mandate participation in any specific health benefit plan; and
8. The limited structural standardization established by this act serves a legitimate public purpose of improving market clarity and stability while preserving private market competition.

(b) It is the purpose of this act to:

1. Require the offering of three (3) comparable health insurance tiers in the individual and small group markets;
2. Establish identical core covered benefits and exclusions within each tier across insurers to enhance transparency;
3. Permit actuarially sound flexibility in deductibles, copayments, and coinsurance within defined ranges;
4. Preserve full competition in premium pricing, network design, service delivery, and operational efficiency;
5. Strengthen consumer choice by improving comparability of coverage options; and
6. Exercise Arkansas's reserved authority to regulate insurance markets consistent with federal and state constitutional provisions.

(c) This act constitutes a clearly articulated state policy to regulate limited aspects of benefit design in order to enhance market competition and shall be interpreted consistent with rational basis review applicable to economic regulation.

SECTION 3. DEFINITIONS.

(a) As used in this act:

1. “Commissioner” means the Arkansas Insurance Commissioner.
2. “Health insurance provider” means any entity authorized to transact accident and health insurance in Arkansas.
3. “Standardized tier plan” means a health benefit plan whose core covered benefits, exclusions, definitions, scope of coverage, and cost-sharing ranges are established by rule under this act.
4. “Covered benefits” means specific medical services, treatments, procedures, and categories of care included within a health benefit plan.
5. “Cost-sharing structure” means deductibles, copayments, coinsurance percentages, and annual out-of-pocket maximums.
6. “Cost-sharing flexibility” means the ability of a health insurance provider to adjust deductibles, copayments, or coinsurance within Commissioner-established ranges while maintaining identical core benefits.
7. “Scope of coverage” means the substantive extent to which a covered benefit is provided, including eligibility criteria, medical necessity standards, quantitative or non-quantitative treatment limitations, utilization management requirements, prior authorization standards, step therapy protocols, visit limits, frequency limits, site-of-service limitations, and any other conditions or limitations affecting access to a covered service.
8. “Uniform in substance and application” means identical in covered services, exclusions, definitions, scope of coverage, conditions of payment, and operational requirements, such that a covered service is treated the same across all insurers offering the same standardized tier.

SECTION 4. REQUIRED COMPARABLE MARKET TIERS.

(a) Offering Requirement.

As a condition of transacting individual or small group health insurance business in Arkansas, each health insurance provider shall offer three (3) standardized tier plans designated as:

1. Tier I – Essential Coverage;
2. Tier II – Enhanced Coverage;
3. Tier III – Comprehensive Coverage.

(b) Commissioner Rulemaking.

The Commissioner shall promulgate rules establishing for each tier:

1. The exact list of core covered benefits;

2. The exact exclusions;
3. Standard actuarially sound ranges for deductible amounts;
4. Standard actuarially sound ranges for copayments and coinsurance percentages;
5. The exact annual out-of-pocket maximum.

(c) Identical Core Structure.

The core covered benefits and exclusions for each standardized tier shall be identical across all health insurance providers operating within the State of Arkansas.

(d) Preserved Flexibility.

Providers may vary deductibles, copayments, and coinsurance within Commissioner-established ranges but shall not alter the core covered benefits or exclusions of a standardized tier plan.

(e) Limited Scope of Displacement.

The tier structure established under this act displaces competition only with respect to defined core benefit design within standardized tiers and shall be actively supervised by the Commissioner. All other aspects of competition remain unaffected.

SECTION 5. PRESERVATION OF MARKET COMPETITION.

(a) No Price Controls.

Nothing in this act:

1. Fixes, mandates, or regulates premium pricing;
2. Establishes reimbursement rates between insurers and healthcare providers;
3. Restricts network composition or provider contracting;
4. Limits actuarially sound underwriting practices permitted by law;
5. Creates or authorizes a government-operated insurance plan.

(b) Additional Plans Permitted.

Health insurance providers may offer additional health benefit plans beyond the three (3) standardized tier plans required under this act, provided that such plans are clearly distinguished from standardized tiers.

(c) Preserved Competitive Factors.

Providers may compete on:

1. Premium pricing;
2. Network design and breadth;
3. Service quality and customer experience;
4. Administrative efficiency;

5. Within-range cost-sharing variation.

SECTION 6. FEDERAL COMPLIANCE AND LIMITATIONS.

(a) This act shall not apply to self-funded employer-sponsored benefit plans governed by the federal Employee Retirement Income Security Act of 1974 (ERISA).

(b) This act shall be applied uniformly to all similarly situated insurers to comply with the Equal Protection Clause.

(c) This act shall apply prospectively only and shall not impair obligations under insurance contracts entered into prior to its effective date.

(d) This act regulates insurance under state authority and shall not be construed to impermissibly burden interstate commerce.

(e) If any provision of this act is found to be preempted by federal law, the remaining provisions shall remain in full force and effect to the maximum extent permitted.

SECTION 7. ENFORCEMENT.

(a) The Commissioner may:

1. Conduct audits and compliance reviews;
2. Impose administrative penalties for noncompliance;
3. Suspend or revoke authorization to transact insurance business for repeated violations.

SECTION 8. RULEMAKING AUTHORITY.

(a) The Commissioner shall promulgate rules necessary to implement this act, including standardized benefit schedules, cost-sharing ranges, and enforcement procedures.

(b) The Commissioner's rulemaking authority under this act shall be guided by actuarial soundness, market stability, consumer affordability, protection of the public health, and compliance with federal law.

SECTION 9. SEVERABILITY.

If any provision of this act or its application is held invalid, such invalidity shall not affect other provisions or applications of the act that can be given effect without the invalid provision or application.

SECTION 15. EFFECTIVE DATE.

This act shall apply to plan years beginning on or after January 1, 20__.