HOUSE AMENDMENT 2 TO hb1843.

deleting Sections 1 through 20 and substituting the following:

"SECTION 1. Short Title.

This act shall be known and may be cited as the Arkansas Health Care Consumer Act.

SECTION 2. Legislative Findings and Intent.

As the State s insurance sector becomes increasingly dominated by managed care features that include decisions regarding coverage and appropriateness of health care, there is a vital need to protect patients in this environment.

SECTION 3. Definitions.

As used in the act:

(1) Acute condition means a medical condition, illness, or disease having a short and relatively severe course.

(2) Commissioner means the Insurance Commissioner of this State.

(3) Covered person means a person on whose behalf the health care insurer issuing or delivering the health benefit plan is obligated to pay benefits pursuant to the health benefit plan.

(4) Health benefit plan means any individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a health care insurer in this state, including indemnity and managed care plans, and including governmental plans as defined in 29 U.S.C. § 1002(32), but excluding plans providing health care services pursuant to Arkansas Constitution, Art. 5, Sec. 32, as amended, the Workers Compensation Law, Ark. Code Ann. 11-9-101 et seq., and the Public Employees Workers Compensation Act, Ark. Code Ann. 21-5-601 et seq.

(5) Health care insurer or insurer means any insurance company, hospital and medical services corporation, or health maintenance organization issuing or delivering health benefit plans in this state and subject to the following laws:

(A) The Arkansas Insurance Code, Ark. Code Ann. § 23-60-101 et seq.;

(B) Ark. Code Ann. § 23-76-101 et seq., pertaining to health maintenance organizations;

(C) Ark. Code Ann. § 23-75-101 et seq., pertaining to hospital and medical service corporations; and

(D) Any successor laws of the foregoing.

(6) Managed care plan means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use participating providers.

(7) Participating provider means a provider who or which has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health care

insurer.

(8) Person means and includes, individually and collectively, any individual, corporation, partnership, firm, trust, association, voluntary organization, or any other form of business enterprise or legal entity. Entity shall have the same meaning.

(9) Policyholder means the employer, union, individual or other person or entity that purchases the health benefit plan.

(10) Specialty means a provider s particular area of specialty within his or her licensed scope of practice.

(11) Type of provider means the licensed scope of practice.

SECTION 4. Benefits for Mothers and Newborns.

(a)(1) Except as provided in subsection (b), a health care insurer may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or to less than ninety-six (96) hours following cesarean section.

(2) A health care insurer may not require that a provider obtain authorization for prescribing any length of stay required under paragraph (1).

(b) Subsection (a)(1) shall not apply if the decision to discharge the mother or her newborn child prior to the expiration of the minimum stay is made by the attending physician in consultation with the mother.

SECTION 5. Mastectomies.

(a) Every health care insurer which provides for the surgical procedure known as mastectomy may not:

(1) Restrict benefits for any hospital length of stay in connection with a mastectomy to less than forty-eight (48) hours, except as provided in paragraph (2).

(2) Paragraph (1) shall not apply in any case in which the decision to discharge the patient prior to the expiration of the minimum length of stay required in paragraph (1) is made by an attending physician in consultation with the patient.

(b) Every health care insurer which provides benefits for mastectomy shall include coverage for prosthetic devices and reconstructive surgery.

SECTION 6. Obstetrical/Gynecological Services.

In order to ensure that health care benefits are safely and appropriately delivered to women, insurers which require the selection or assignment of a primary care physician shall allow covered persons who are women to select a participating obstetrician/gynecologist in addition to her primary care physician. If the woman chooses to make this selection, the insurer shall allow the woman to go directly to her selected obstetrician/gynecologist, without referral from her primary care physician, for obstetrical and gynecological services.

SECTION 7. Gag Clause Prohibition.

No participating provider may be prohibited, restricted or penalized in any way from disclosing to any covered person any health care information that such provider deems

appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny health care services or benefits, or information on financial incentives and structures used by the insurer.

SECTION 8. Continuity of Care.

(a) When health care insurers use participating providers, the insurers shall develop procedures to provide for the continuity of care of their covered persons. Such procedures shall, at a minimum:

(1) Ensure that when a new patient is enrolled in a health benefit plan and is being treated by a non-participating provider for a current episode of an acute condition, the patient may continue to receive treatment as an in-network benefit from that provider until the current episode of treatment ends or until the end of ninety (90) days, whichever occurs first.

(2) Ensure that when a provider's participation is terminated, his or her patients under the plan may continue to receive care from that provider as an in-network benefit until a current episode of treatment for an acute condition is completed or until the end of ninety (90) days, whichever occurs first.

(3) Explain how the covered person may request to continue services under (1) and (2).

(b) During the period covered by (1) and (2), the provider shall be deemed to be a participating provider for purposes of reimbursement, utilization management, and quality of care.

(c) Nothing in this section shall require a health care insurer to provide benefits that are not otherwise covered under the terms and provisions of the plan.

SECTION 9. Prescription Drug Formulary.

When a health care insurer uses a formulary for prescription drugs, such insurer shall include a written procedure whereby covered persons can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the formulary when:

(1) the formulary's equivalent has been ineffective in the treatment of the covered person's disease or condition; or

(2) the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the covered person.

SECTION 10. Grievance Procedures.

(a) A health care insurer issuing or delivering a managed care plan shall establish for those managed care plans a grievance procedure which provides covered persons with a prompt and meaningful review on the issue of denial, in whole or in part, of a health care treatment or service.

(b) The covered person shall be provided prompt notice in writing of the outcome of the grievance procedure. In the event the outcome is adverse to the covered person, the

notice shall include specific findings related to the grievance.

SECTION 11. Processing Applications of Providers.

(a) Health care insurers shall establish mechanisms to ensure timely processing of requests for participation or renewal by providers, and in making decisions that affect participation status. These mechanisms shall include, at a minimum, provisions for the provider to receive a written statement of reasons for the health care insurer's denial of a request for initial participation or renewal; and

(b) Health care insurers shall make a decision within one hundred eighty (180) days of submission of a completed application for participation or a request for renewal;

(c) Nothing in this act shall prevent a provider or a health care insurer from terminating a participating provider contract in accordance with its terms.

SECTION 12. Provider Input.

All health care insurers issuing or delivering managed care plans shall be required to establish a mechanism whereby participating providers provide input into the insurer's medical policy, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.

SECTION 13. Disclosure Requirements.

(a) Upon request, health care insurers must provide the following information in a clear and understandable form to all prospective policyholders, policyholders and covered persons. Insurers shall notify policyholders and covered persons of their right to request such information, which must include:

(1) Coverage provisions, benefits, and exclusions by category of service and provider;

(2) A description of the prior authorization, precertification, and referral requirements;

(3) The existence of prescription drug formularies and prior approval requirements for prescription drugs;

(4) The name, number, type, specialty and geographic location of participating providers; and

(5) Criteria by which providers are evaluated for network participation. Proprietary information shall not be disclosed. Criteria may include, but are not limited to, geographic limitations, geographic distribution of patients, specialty limitation, anticipated numbers and types of providers needed, and economic considerations. This information shall also be made available to providers upon request.

SECTION 14. Regulations.

The commissioner may promulgate necessary rules and regulations for carrying out this act.

SECTION 15. Enforcement and Penalties.

The commissioner shall have all the powers to enforce this act as are granted to the commissioner elsewhere in the Arkansas Insurance Code, Ark. Code Ann. § 23-60-101 et seq.

SECTION 16. Effective Date.

This act applies to all health benefit plans issued, renewed, extended or modified on or after the effective date of this act. Renewed, extended or modified shall include all health benefit plans in which the insurer has reserved the right to change the premium."

AND

by appropriately renumbering subsequent sections of the bill.