ARKANSAS SENATE

95th General Assembly - Regular Session, 2025

Amendment Form

Subtitle of Senate Bill 626

TO REQUIRE FAIR AND TRANSPARENT REIMBURSEMENT RATES; TO ENSURE PARITY OF HEALTHCARE SERVICES; TO AMEND THE BILLING IN THE BEST INTEREST OF PATIENTS ACT; AND TO DECLARE AN EMERGENCY.

Amendment No. 1 to Senate Bill 626

Amend Senate Bill 626 as originally introduced:

Page 1, delete lines 30 through 35, and substitute the following:

"(1) Arkansas's healthcare providers are at a significant disadvantage as a result of national reimbursement methodologies and receive some of the lowest commercial rates in the country;"

AND

Page 2, delete lines 14 through 36, and substitute the following:

"(b) It is the intent of the General Assembly to:

(1) Ensure fair and equitable reimbursement rates for healthcare clinics, hospitals, medical or imaging services performed at licensed ambulatory surgical centers, outpatient psychiatric centers, and outpatient imaging facilities; and

(2) Require insurers to:

(A) Reimburse healthcare clinics, hospitals, medical or imaging services performed at licensed ambulatory surgical centers, outpatient psychiatric centers, and outpatient imaging facilities fairly and equitably;

(B) Disclose the insurer's reimbursement methodologies; and

(C) Ensure minimum reimbursement rates for healthcare

clinics, hospitals, medical or imaging services performed at licensed ambulatory surgical centers, outpatient psychiatric centers, and outpatient imaging facilities."

AND

Page 3, delete lines 1 through 36, and substitute the following:

"SECTION 2. Arkansas Code Title 23, Chapter 99, is amended to add an additional subchapter to read as follows:

Subchapter 20 — Minimum Reimbursement Rates for Healthcare Services

23-99-2001. Definitions.

As used in this subchapter:

(1) "Adjoining states" means Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas;

(2) "Ambulatory surgery center" means an entity certified by the Department of Health as an ambulatory surgery center that operates for the purpose of providing surgical services to patients;

(3)(A) "Equivalent Medicare reimbursement" means the amount, based on prevailing reimbursement rates and methodologies, that a healthcare provider or health system is entitled to for healthcare services.

(B)(i) "Equivalent Medicare reimbursement" includes services that are not covered by Medicare or are set locally by Medicare contractors.

(ii) Services under this subdivision (3) will be priced at the healthcare provider's overall prevailing Medicare reimbursement collection-to-charge ratio;

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

(B) "Health benefit plan" includes any group plan, policy, or contract for healthcare services issued outside this state that provides benefits to residents of this state.

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

(i) A plan that provides only dental benefits;

(ii) A plan that provides only eye and vision

benefits;

(iii) A disability income plan;

(iv) A credit insurance plan;

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

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

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

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

(ix) An accident-only plan;

(x) A specified disease plan;

(xi) A policy, contract, certificate, or agreement offered or issued by a healthcare insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including pharmacy benefits, to an entity of the state under § 21-5-401 et seq;

(xii) A qualified health plan that is a health benefit plan under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and purchased on the Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an individual up to four hundred percent (400%) of the federal poverty level;

(xiii) A health benefit plan provided by a trust established under § 14-54-104 to provide benefits, including accident and health benefits, death benefits, dental benefits, and disability income benefits;

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

(xv) A health benefit plan provided by an institution of higher education;

(5) "Health system" means an organization that owns or operates more than one (1) hospital;

(6)(A) "Healthcare insurer" means an entity that is authorized by this state to offer or provide health benefit plans, policies, subscriber contracts, or any other contracts of a similar nature that indemnify or

compensate a healthcare provider for the provision of healthcare services.

(B) "Healthcare insurer" includes without limitation:

(i) An insurance company;

(ii) A health maintenance organization;

(iii) A hospital and medical service corporation; and

(iv) An entity that provides or administers a self-funded health benefit plan.

(C) "Healthcare insurer" does not include:

(i) The Arkansas Medicaid Program;

(ii) The Arkansas Health and Opportunity for Me Program under the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., or any successor program;

(iii) A provider-led Arkansas shared savings entity;

(iv) An entity that offers a plan providing health benefits to state and public school employees under § 21-5-401 et seq.; or

(v) An entity that offers a plan providing health benefits to an institution of higher education;

(7) "Healthcare provider" means:

(A) A hospital;

(B) A health system;

(C) A physician;

(D)(i) A physician extender.

(ii) A physician extender includes without limitation:

(a) A physician assistant who is licensed in this state;

(b) A nurse practitioner who is licensed in this state;

(c) An advanced practice nurse who is licensed in this state; and

(d) A certified midwife who is licensed in this state;

(E) A licensed ambulatory surgery center; and

(F) An outpatient facility that performs healthcare services, including without limitation primary care clinics, urgent care

centers, specialty clinics, dialysis centers, and imaging centers;

(8) "Healthcare service" means a service or good that is provided for the purpose of or incidental to the purpose of preventing, diagnosing, treating, alleviating curing, or healing human illness, disease, condition, disability, or injury;

(9) "Hospital" means a healthcare facility licensed as a hospital by the Division of Health Facilities Services under § 20-9-213;

(10) "Minimum reimbursement level" means the minimum ratio of reimbursement to equivalent Medicare reimbursement that a healthcare provider or health system is entitled to by a healthcare insurer for healthcare services;

(11) "Outpatient imaging facility" means a healthcare facility or provider that provides diagnostic and advanced imaging services to patients and uses Current Procedural Terminology codes 70010–79999 to bill for the facility component of imaging services;

(12) "Physician" means a person authorized or licensed to practice medicine under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.; and

(13) "Reimbursement rate" means the amount that a healthcare provider is entitled to receive for healthcare services.

23-99-2002. Minimum reimbursement level.

(a)(1) A health benefit plan shall reimburse a healthcare provider that provides a healthcare service the minimum reimbursement level for the healthcare service as determined by the Insurance Commissioner.

(2) The commissioner is not required to establish a minimum reimbursement level for each healthcare service.

(3) The minimum reimbursement level shall be established at the healthcare provider's contract level based on the healthcare provider's specific compliment of services.

(b) The minimum reimbursement level under subdivision (a)(1) of this section shall be phased in according to the schedule below:

(1) On or after January 1, 2026, forty-five percent (45%);

(2) On or after January 1, 2027, fifty-five percent (55%);

(3) On or after January 1, 2028, sixty-five percent (65%);

(4) On or after January 1, 2029, seventy-five percent (75%); and

(5) On or after January 1, 2030, one hundred percent (100%).

(c)(1) The commissioner shall determine the minimum reimbursement level for a healthcare service by calculating the weighted average ratio of commercial prices as a percentage of Medicare reimbursement for the healthcare service in adjoining states as derived from the RAND Corporation's Prices Paid to Hospitals by Private Plans findings as adopted by rule of the commissioner.

(2) If the RAND Corporation's Prices Paid to Hospitals by Private Plans findings are discontinued, delayed, or deemed unsuitable by the commissioner, the commissioner shall compute an adjusted ratio of commercial prices as a percentage of Medicare by applying a factor of the annual change in the Consumer Price Index: Medical Care, commonly known as the "medical care index", published by the United States Bureau of Labor Statistics and adopted by rule of the commissioner to the weighted average increase of Medicare reimbursement for a healthcare provider to the most recently published minimum reimbursement level.

(d) Beginning September 1, 2025, the commissioner shall publish annually on the State Insurance Department's website the minimum reimbursement level as determined under subsection (c) of this section.

23-99-2003. Disclosures.

(a)(1) A healthcare insurer shall document compliance with this subchapter for each healthcare provider.

(2) A healthcare insurer shall include documentation of compliance required in subdivision (a)(1) of this section for each health benefit plan offered by the healthcare insurer to a healthcare provider.

(b)(1) A healthcare insurer shall disclose to each contracted healthcare provider summary documentation, including the supporting detailed calculations and assumptions.

(2) The summary documentation under subdivision (b)(1) of this section shall be made available to:

(A) The contracted healthcare provider before the execution or renewal of a contract and within fifteen (15) days of a formal request; and

(B) The Insurance Commissioner within fifteen (15) days of a formal request.

23-99-2004. Enforcement.

(a) A dispute under this subchapter shall be filed with the Insurance Commissioner.

(b)(1) After notice and opportunity for a hearing, if a healthcare insurer or a health benefit plan is found to have violated this subchapter, the commissioner may revoke or suspend the authority of the healthcare insurer or health benefit plan to do business in this state.

(2) The commissioner shall rule on a dispute within sixty (60) days.

(c) A healthcare insurer or health benefit plan that has violated this subchapter shall be required to repay the healthcare provider all amounts in violation of this subchapter plus eight percent (8%) interest and five percent (5%) in administrative fees, inclusive of amounts otherwise due from the patient.

23-99-2005. Prohibition on pricing increases.

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

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

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

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

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

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

(iii) Cost sharing.

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

23-99-2006. Rules.

The Insurance Commissioner may promulgate rules to implement and enforce this subchapter.

23-99-2007. Remedies and penalties.

(a) This subchapter shall not be waived by contract.

(b) An agreement or other arrangement that violates this subchapter is void.

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

(d) A violation of this section is a deceptive act, as defined by the Trade Practices Act, § 23-66-201 et seq., and § 4-88-101 et seq. except that the statute of limitations for private causes of action against an insurer by a healthcare provider shall be five (5) years for a violation of this section."

AND

Page 4, delete lines 1 through 36

AND

Page 5, delete lines 1 through 36

AND

Page 6, delete lines 1 through 36

AND

Page 7, delete lines 1 through 36

AND

Page 8, delete lines 1 through 36

AND

Page 9, delete lines 1 through 36

AND

Page 10, delete lines 1 through 36

AND

Page 11, delete line 1

AND

Appropriately renumber the sections of the bill

The Amendment was read the first time, rules suspended and read the second time and _____

By: Senator Irvin

ANS/ANS - 04-08-2025 04:26:41

_____

ANS513 **Secretary**