As Engrossed: 3/16/93

State of Arkansas
79th General Assembly
Regular Session, 1993
By: Representative Landers

A Bill

HOUSE BILL 2042

For An Act To Be Entitled

"AN ACT TO ESTABLISH MINIMUM STANDARDS FOR PREFERRED PROVIDER ARRANGEMENTS; AND FOR OTHER PURPOSES."

Subtitle

"TO PROVIDE MINIMUM STANDARDS FOR PREFERRED PROVIDER ARRANGEMENTS."

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

SECTION 1. This Act shall be knows and may be cited as the "Preferred Provider Arrangements Act."

SECTION 2. The purpose of this Act is to encourage health care cost containment while preserving quality of care by allowing health care insurers to enter into preferred provider arrangements and by establishing minimum standards for preferred provider arrangements and the health benefit plans associated with those arrangements.

SECTION 3. Definitions. The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

(a) Commissioner - The Insurance Commissioner of the state of Arkansas.

(b) Covered Person - Any person on whose behalf the health care insurer is obligated to pay for or provide health care services.

(c) Covered Services - Health care services which the health care insurer is obligated to pay for or provide under the Health Benefit Plan.

(d) Emergency Care - Covered services delivered to a covered person who has suffered an accidental bodily injury or contracted a medical condition

which reasonably requires the beneficiary or insured to seek immediate medical care under circumstances or at locations which reasonably preclude the beneficiary or insured from obtaining needed medical care from a preferred provider.

(e) Health Benefit Plan - The health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available.

(f) Health Care Insurer - An insurance company as defined in §23-62-103, a hospital or medical services corporation as defined in §23-75-101 et seq., a health maintenance organization as defined in §23-76-101 et seq., or a fraternal benefit society as defined in §23-74-101 et seq.

(g) Health Care Provider - Providers of health care services licensed as required in this state.

(h) Health Care Services - Services rendered or products sold by a health care provider within the scope of the provider_s license. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

(i) Preferred Provider. A health care provider or group of providers who have contracted to provide specified covered services.

(j) Preferred Provider Arrangement - A contract between or on behalf of the health care insurer and a preferred provider which complies with all the requirements of this act.

SECTION 4. Preferred Provider Arrangements. Notwithstanding any provisions of law to the contrary, any health care insurer may enter into Preferred Provider Arrangements.

(a) Such arrangements shall:

(1) Establish the amount and manner of payment to the preferred provider. Such amount and manner of payment may include capitation payments for preferred providers.

(2) Include mechanisms which are designed to minimize the cost of the health benefit plan. These mechanisms may include among others:

(A) The review or control of utilization of health care services.

(B) A procedure for determining whether health care services rendered are medically necessary.

(3) Assure reasonable access to covered services available under the Preferred Provider Arrangement and an adequate number of preferred providers to render those services.

(b) Such arrangements shall not unfairly deny health benefits for medically necessary covered services.

(c) If an entity enters into a contract providing covered services with a health care provider, but is not engaged in activities which would require it to be licensed as a health care insurer, such entity shall file with the Insurance Commissioner information describing its activities and a description of the contract or agreement it has entered into with the health care providers. Employers who enter into contracts with health care providers for the exclusive benefit of their employees and dependents are exempt from this requirement.

SECTION 5. Health Benefit Plans.

(a) Health care insurers may issue health benefit plans which provide for incentives for covered persons to use the health care services of preferred providers. Such policies or subscriber agreements shall contain at least the following provision:

(1) A provision that if a covered person receives emergency care for services specified in the Preferred Provider Arrangement and cannot reasonably reach a preferred provider that emergency care rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider; and

(2) A provision which clearly identifies the differentials in benefit levels for health care services of preferred providers and benefit levels for health care services of non-preferred providers.

(b) If a health benefit plan provides differences in benefit levels payable to preferred providers compared to other providers, such differences shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider. No health benefit plan shall provide differences in benefit levels of greater than twenty-five percent (25%) unless the Commissioner establishes greater allowable differences in benefit levels through regulation.

SECTION 6. Preferred Provider Participation Requirements. Health Care Insurers must enter into Preferred Provider Arrangements with at least one Health Provider licensed under each of the following chapters of Subtitle 3 of Title 17 of the Arkansas Code of 1987: 81, 89, 93, 95, 96 and 79, unless the Health Benefit Plan does not provide for services within the lawful scope of the license provided by such chapter. Health care insurers may place reasonable limits on the number of preferred providers which satisfy the standards set forth by the health care insurer, provided that there be no discrimination against providers on the basis of religion, race, color, national origin, age, sex or marital status, and further provided that selection of preferred providers is primarily based on, but not limited to, cost and availability of covered services and the quality of services performed by the providers.

SECTION 7. General Requirements. Health care insurers complying with this act shall be subject to and are required to comply with all other applicable laws, rules and regulations of this state.

SECTION 8. Regulations. The Commissioner may promulgate regulations necessary to the enforcement and administration of this act.

SECTION *9*. All provisions of this act of a general and permanent nature are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas Code Revision Commission shall incorporate the same in the Code.

SECTION *10*. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

SECTION *11*. All laws and parts of laws in conflict with this act are hereby repealed.

/s/Rep. Landers