State of Arkansas
80th General Assembly
Regular Session, 1995
By: Representative Dawson

A Bill

HOUSE BILL 2071

For An Act To Be Entitled

"AN ACT TO REQUIRE DISCLOSURE OF INFORMATION REGARDING CONTRACTUAL PROVISIONS WITH HOSPITALS, REVIEW COMPANIES, PHYSICIANS OR ANY OTHER HEALTH CARE PROVIDER THAT RESTRICT REFERRAL OR TREATMENT OPTIONS AND OTHER INFORMATION REGARDING HEALTH BENEFITS PLANS; AND FOR OTHER PURPOSES."

Subtitle

"TO REQUIRE DISCLOSURE OF INFORMATION REGARDING CONTRACTUAL PROVISIONS WITH HOSPITALS, REVIEW COMPANIES, PHYSICIANS OR ANY OTHER HEALTH CARE PROVIDER THAT RESTRICT REFERRAL OR TREATMENT OPTIONS."

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

SECTION 1. (a) For purposes of this act, "health benefit plan" means any entity or program that provides reimbursement, including capitation, for health care services, except and excluding any entity or program that provides reimbursement and benefits pursuant to Amendment 26 to the Constitution of the State of Arkansas, the "Workers' Compensation Law," Arkansas Code 11-9-101, et seq., or the "Public Employees Workers Compensation Act," Arkansas Code 21-5-601, et seq., and rules, regulations and schedules adopted thereunder.

(b) The State Insurance Department shall establish standards for the disclosure of information to prospective enrollees and current enrollees about health benefits plans. Prospective enrollees and current enrollees in health insurance plans shall be provided information as to the terms and conditions of the plan so that they can make informed decisions about

accepting a certain system of health care delivery. Where the plan is described orally to enrollees, easily understood, truthful, and objective terms must be used. All written plan descriptions must be in a readable and understandable format. Specific items that must be included are:

(1) coverage provisions, benefits, *prescription drug formularies, treatment guidelines* and any exclusions by category of service, provider or physician, and if applicable by specific service;

(2) any and all prior authorization or other review requirements including pre-authorization review, concurrent review, post-service review, post-payment review and any procedures that may lead the patient to be denied coverage for or not be provided a particular service;

(3) financial arrangements or contractual provisions with hospitals, review companies, physicians or any other provider of health care services that would limit the services offered, restrict referral or treatment options, or negatively affect the physician_s fiduciary responsibility to his or her patients, including but not limited to financial incentives not to provide medical or other services;

(4) explanation of how plan limitations impact enrollees, including information on enrollee financial responsibility for payment for coinsurance or other non-covered or out-of-plan services;

(5) medical benefit payment to premium rations;

(6) enrollee satisfaction statistics*; and*

(7) methodology for providers to be able to over-ride non-covered procedures and non-formulary drugs for medically necessary indications.

SECTION 2. (a) For purposes of this subparagraph, the term "physician incentive plan" means any compensation arrangement between the plan and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individual enrolled in the plan.

(b) Any health benefit plan that operates a physician incentive plan must meet the following requirements:

(1) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit

medically necessary services provided with respect to an individual patient;

(2) If the plan places a physician or physician group at financial risk for services not provided by the physician or physician group, the plan provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the State Insurance Department, that take into account the number of physicians placed at such financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or physician group.

SECTION 3. Whenever coverage provisions, benefits, prescription drug formularies, or treatment guidelines undergo additions or deletions or other substantive revisions, such revisions must be developed by a process that includes the participation of providers contracting with the plan. Copies of the revisions shall be made available to participating providers and plan enrollees.

SECTION *4*. 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 *5*. 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 *6*. All laws and parts of laws in conflict with this act are hereby repealed.

/s/Rep. Dawson