

Stricken language would be deleted from present law. Underlined language would be added to present law.

1 State of Arkansas  
2 81st General Assembly  
3 Regular Session, 1997

As Engrossed: H2/28/97 H3/17/97

## A Bill

HOUSE BILL 1843

4

5 *By: Representatives Young, Molinaro, Allison, Angel, Bond, Booker, Broadway, Brown, Capps, Cunningham, Ferguson, George,*  
6 *Goodwin, Hall, Horn, D. Hudson, Johnson, Jones, Kidd, Laverty, Lynn, Madison, Malone, McGee, McKissack, Miller, Northcutt,*  
7 *Pollan, Roberts, Schexnayder, Sheppard, Shoffner, Judy Smith, Terry Smith, Teague, Trammell, Walker, Wilkinson, Wilson, Wood,*  
8 *Wooldridge, and Wren*

9 *By: Senators Argue, Gwatney, Smith, and Mahoney*

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### For An Act To Be Entitled

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"AN ACT TO REQUIRE HEALTH CARE INSURERS TO PROVIDE

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MINIMUM BENEFITS FOR MOTHERS AND NEWBORNS, TO MEET

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CERTAIN MASTECTOMY STANDARDS, AND TO PROVIDE CONSUMER

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PROTECTION IN MANAGED CARE PLANS; AND FOR OTHER PURPOSES."

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### Subtitle

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"AN ACT TO BE ENTITLED THE ARKANSAS

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HEALTH CARE CONSUMER ACT."

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

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24 *SECTION 1. Short Title.*

25 *This act shall be known and may be cited as the "Arkansas Health Care*

26 *Consumer Act."*

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28 *SECTION 2. Legislative Findings and Intent.*

29 *As the States insurance sector becomes increasingly dominated by*

30 *managed care features that include decisions regarding coverage and*

31 *appropriateness of health care, there is a vital need to protect patients in*

32 *this environment.*

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34 *SECTION 3. Definitions.*

35 *As used in the act:*

36 *(1) "Acute condition" means a medical condition, illness, or disease*

1 having a short and relatively severe course.

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

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

6 (4) "Health benefit plan" means any individual, blanket, or group plan,  
7 policy, or contract for health care services issued or delivered by a health  
8 care insurer in this state, including indemnity and managed care plans, and  
9 including governmental plans as defined in 29 U.S.C. § 1002(32), but excluding  
10 plans providing health care services pursuant to Arkansas Constitution, Art.  
11 5, Sec. 32, as amended, the Workers Compensation Law, Ark. Code Ann. 11-9-101  
12 et seq., and the Public Employees Workers Compensation Act, Ark. Code Ann.  
13 21-5-601 et seq.

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

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

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

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

24 (D) Any successor laws of the foregoing.

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

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

32 (8) "Person" means and includes, individually and collectively, any  
33 individual, corporation, partnership, firm, trust, association, voluntary  
34 organization, or any other form of business enterprise or legal entity.

35 "Entity" shall have the same meaning.

36 (9) "Policyholder" means the employer, union, individual or other person

1 or entity that purchases the health benefit plan.

2 (10) "Specialty" means a providers particular area of specialty within  
3 his or her licensed scope of practice.

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

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6 SECTION 4. Benefits for Mothers and Newborns.

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

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

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

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18 SECTION 5. Mastectomies.

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

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

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

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

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31 SECTION 6. Obstetrical/Gynecological Services.

32 In order to ensure that health care benefits are safely and  
33 appropriately delivered to women, insurers which require the selection or  
34 assignment of a primary care physician shall allow covered persons who are  
35 women to select a participating obstetrician/gynecologist in addition to her  
36 primary care physician. If the woman chooses to make this selection, the

1 insurer shall allow the woman to go directly to her selected  
2 obstetrician/gynecologist, without referral from her primary care physician,  
3 for obstetrical and gynecological services.

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5 SECTION 7. "Gag Clause" Prohibition.

6 No participating provider may be prohibited, restricted or penalized in  
7 any way from disclosing to any covered person any health care information that  
8 such provider deems appropriate regarding the nature of treatment, risks or  
9 alternatives thereto, the availability of alternate therapies, consultations,  
10 or tests, the decision of utilization reviewers or similar persons to  
11 authorize or deny services, the process that is used to authorize or deny  
12 health care services or benefits, or information on financial incentives and  
13 structures used by the insurer.

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15 SECTION 8. Continuity of Care.

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

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

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

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

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

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

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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.

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

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7 SECTION 13. Disclosure Requirements.

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

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

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

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

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

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

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28 SECTION 14. Regulations.

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

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32 SECTION 15. Enforcement and Penalties.

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

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1           SECTION 16. Effective Date.

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

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8           SECTION 17. All provisions of this Act of a general and permanent  
9 nature are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas  
10 Code Revision Commission shall incorporate the same in the Code.

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12           SECTION 18. If any provision of this Act or the application thereof to  
13 any person or circumstance is held invalid, such invalidity shall not affect  
14 other provisions or applications of the Act which can be given effect without  
15 the invalid provision or application, and to this end the provisions of this  
16 Act are declared to be severable.

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18           SECTION 19. All laws and parts of laws in conflict with the Act are  
19 hereby repealed.

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/s/Rep. Young, et al

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