**Stricken language would be deleted from and underlined language would be added to law as it existed prior to the 82nd General Assembly.**

State of Arkansas *As Engrossed: H4/2/99*
82nd General Assembly **A Bill**
Regular Session, 1999 HOUSE BILL 2171

By: Representatives Faris, T. Smith

## For An Act To Be Entitled

"AN ACT TO AMEND ARKANSAS CODE 23-76-119 RELATING TO HEALTH MAINTENANCE ORGANIZATIONS, TO PROVIDE CERTAIN PATIENT PROTECTIONS FOR HEALTH MAINTENANCE ORGANIZATION ENROLLEES; AND FOR OTHER PURPOSES."

## Subtitle

"TO PROVIDE PATIENT PROTECTIONS FOR HEALTH MAINTENANCE ORGANIZATION ENROLLEES."

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

SECTION 1. Arkansas Code 23-76-119 is hereby amended to read as follows:

"(a) No Health Maintenance Organization, or representative thereof, may knowingly cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this chapter:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan;

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding

health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist;

(3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing the evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

(b) An enrollee may not be cancelled or nonrenewed except for the failure to pay the charge for the coverage or for such other reasons as may be promulgated by the commissioner.

(c) Any Health Maintenance Organization which commits violations of Ark. Code Ann. §23-76-118 (b)(3) with such frequency as to indicate a general business practice shall have committed an unfair claims settlement practice as defined in Ark. Code Ann. §23-66-206 (9).

(d) No Health Maintenance Organization shall offer any evidence of coverage, or amendment thereto to any person in this state without also offering to the enrollee an additional option of:

(1) A point of service option which provides benefits for covered services through health professionals and providers who are not members of the Health Maintenance Organization's medical provider network;

(2) The Health Maintenance Organization shall fully disclose to the enrollee, in clear, understandable language, the terms and conditions of each option, the co-payments or other cost-sharing features of each option and the costs associated with each such option provided by the issuer. The commissioner may promulgate rules regarding presentation of these terms and conditions, including a suggested standard format, to facilitate the comparison by the enrollee of the terms and conditions of each option. The obligation of a Health Maintenance Organization to make the offer described in this section may be satisfied by the Health Maintenance Organization providing

to the employer or other plan sponsor presentation materials for dissemination to employees or principal enrollees.

(3) The amount of any additional premium required for the options described in subsection (2) may be paid by the purchaser of the health plan or may be paid by the enrollee of such group. Such additional premium, taking *into account any co-payments or other cost-sharing features, which shall not be waived by the provider, shall not exceed* an amount that is fair and reasonable in relation to the benefits provided, as determined by the Insurance Commissioner, in regulations.

*(4) Under the option described in subsection (2), the rate of reimbursement for health providers out of the network shall be no higher than the normal and usual and customary rate charged by those out of network providers on a regular basis, provided that co-payment, co-insurance and other cost-sharing features may be different for out-of-network providers than in-network providers.*

*(5) The option described in subsection (2) shall be a part of every contract issued by a Health Maintenance Organization.*

(e) No managed care plan of the Health Maintenance Organization and the provider shall provide for any financial incentive which compensates a health care provider for providing less than medically necessary and appropriate care to an enrollee. Nothing in this section shall be deemed to prohibit a managed care plan from using a capitated payment arrangement or other risk-sharing arrangement.

(f) No health maintenance organization shall provide, directly or indirectly, any financial incentive or disincentive, or grant or deny any special favor or advantage of any kind or nature whatsoever, to any person to encourage or cause early discharge of a hospital inpatient from postpartum care. Notwithstanding the above, this section does not prohibit use of prospective payment systems including, but not limited to, capitation and diagnostic related groupings, that are designed to promote efficiency in appropriate health care delivery.

(g) No Health Maintenance Organization shall offer any evidence of coverage, or amendment thereto to any person in this state without also providing in the plan for the continuity of care following a termination of any contract with a participating health care provider:

(1) The plan shall provide for continuity of care at the

enrollee's option, for a transitional period of up to sixty (60) days from the date the enrollee was notified by the plan of the termination or pending termination. The managed care plan, in consultation with the enrollee and the health care provider, may extend the transitional period if determined to be clinically appropriate. In the case of an enrollee in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care *related to the delivery.*

(2) If the plan terminates the contract of a participating health care provider for cause, including breach of contract, fraud, criminal activity or posing a danger to an enrollee or the health, safety or welfare of the public as determined by the plan, the plan shall not be responsible for health care services provided to the enrollee following the date of termination.

(3) If the plan terminates the contract of a participating primary care provider, the plan shall notify every enrollee served by that provider of the plan's termination of its contract and shall request that the enrollee select another primary care provider.

(4) A new enrollee may continue an ongoing course of treatment with a nonparticipating health care provider for a transitional period of up to sixty (60) days from the effective date of enrollment in a managed care plan. The managed care plan, in consultation with the enrollee and the health care provider, may extend this transitional period if determined to be clinically appropriate. In the case of a new enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional *period shall extend through postpartum care related to the delivery.*

*(5)* Nothing in this section shall require a managed care plan to provide health care services that are not otherwise covered under the terms and conditions of the plan."

SECTION 2. 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 3. 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 4. All laws and parts of laws in conflict with this act are hereby repealed.

*/s/ Faris, et al*