State of Arkansas
94th General Assembly
Regular Session, 2023

A Bill

HOUSE BILL 1348

By: Representative L. Johnson

For An Act To Be Entitled

AN ACT TO ESTABLISH A STATE AUDIT PROCESS CONCERNING QUALIFIED PAYMENT AMOUNTS; TO ENHANCE TRANSPARENCY BY RELEASING STATE AUDIT RESULTS; AND FOR OTHER PURPOSES.

Subtitle

TO ESTABLISH A STATE AUDIT PROCESS CONCERNING QUALIFIED PAYMENT AMOUNTS; AND TO ENHANCE TRANSPARENCY BY RELEASING STATE AUDIT RESULTS.

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

SECTION 1. Arkansas Code Title 23, Chapter 66, Subchapter 2, is amended to add an additional section to read as follows:

23-66-216. Qualified payment amount — Audit required — Definitions.

(a) As used in this section:

(1)(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, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state.

(B) "Health benefit plan" includes indemnity and managed care plans.

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

(i) A plan that provides only dental benefits or eye and vision care benefits;

(ii) A disability income plan;

(iii) A credit insurance plan;

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

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

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

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

(viii) An accident-only plan;

(ix) A specified disease plan;

(x) A program established by the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.; or

(xi) Plans providing health benefits to state and public school employees under § 21-5-401 et seq.;

(2)(A) "Healthcare insurer" means any insurance company, hospital and medical service corporation, or health maintenance organization that issues or delivers health benefit plans in this state and is subject to any of the following laws:

(i) The insurance laws of this state;

(ii) Section 23-75-101 et seq., pertaining to hospital and medical service corporations; or

(iii) Section 23-76-101 et seq., pertaining to health maintenance organizations.

(B) "Healthcare insurer" does not include an entity that provides only dental benefits or eye and vision care benefits; and

(3) "Healthcare professional" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession.

(b)(1) The Insurance Commissioner shall establish a state audit process to ensure compliance with the requirements stated in the No Surprises Act of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, related to the calculation of a qualified payment amount.

(2) The results of the audit shall be available to the public.

(c) The commissioner shall develop the state audit process under subdivision (b)(1) of this section to:

(1) Ensure the health benefit plan or healthcare insurer calculates the qualified payment amount according to the methodology established under the No Surprises Act of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260;

(2) Review the contractual language and negotiated rate for each contract used to calculate the qualified payment amount;

(3) Beginning in the plan year four (4) years before the current plan year, review the percentage volume of adjudicated claims for the relevant Current Procedural Terminology code associated with:

(A) Every contract issued by the healthcare insurer;

(B) Each contract identified as the qualified payment amount;

(C) Every contract above the qualified payment amount; and

(D) Every contract below the qualified payment amount;

(4) Review the number of contracts included in the qualified payment amount calculation under which zero (0) claims were adjudicated for the relevant Current Procedural Terminology code beginning in the plan year four (4) years before the current plan year;

(5) Review the specialty of the healthcare professional associated with each contract, as identified under the healthcare insurer's standard business practice and highlight whether the specialty of the healthcare professional associated with each contract differs from the specialty of the billing healthcare professional that received the qualified payment amount;

(6) Examine the exclusions, including those paid under single case agreement, the health benefit plan used when calculating the qualified payment amount;

(7)(A) Examine whether or not the health benefit plan included contracted rates that have since been determined to be inappropriate based on updated guidance issued under the No Surprises Act of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, including without limitation "ghost rates".

(B) If the associated claim was adjudicated before the end of the ninety-day compliance period established under the No Surprises Act of

the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, review the actions of the health benefit plan to determine if the health benefit plan understands the implications of any revised guidance issued under the No Surprises Act of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260; and

(8) Identify any irregularities to the calculations by the health benefit plan and report the irregularities to the Centers for Medicare & Medicaid Services for further action to ensure compliance with the No Surprises Act of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260.

(d) The commissioner shall promulgate rules to implement and administer this section.

SECTION 2. DO NOT CODIFY. EFFECTIVE DATE.

This act is effective on and after January 1, 2024.

SECTION 3. DO NOT CODIFY. Rules.

(a) When adopting the initial rules required under this act, the Insurance Commissioner shall file the final rules with the Secretary of State for adoption under § 25-15-204(f):

(1) On or before January 1, 2024; or

(2) If approval under § 10-3-309 has not occurred by January 1, 2024, as soon as practicable after approval under § 10-3-309.

(b) The commissioner shall file the proposed rules with the Legislative Council under § 10-3-309(c) sufficiently in advance of January 1, 2024, so that the Legislative Council may consider the rules for approval before January 1, 2024.