State of Arkansas
95th General Assembly
Regular Session, 2025

A Bill

SENATE BILL 626

By: Senator Irvin
By: Representative L. Johnson

For An Act To Be Entitled

AN ACT TO AMEND THE LAW CONCERNING HEALTHCARE PROVIDER REIMBURSEMENT; TO REQUIRE FAIR AND TRANSPARENT REIMBURSEMENT RATES FOR LICENSED AMBULATORY SURGICAL CENTERS, OUTPATIENT PSYCHIATRIC CENTERS, AND OUTPATIENT IMAGING FACILITIES; TO ENSURE PARITY IN INSURANCE PAYMENTS FOR HEALTHCARE SERVICES; TO AMEND THE BILLING IN THE BEST INTEREST OF PATIENTS ACT; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO REQUIRE FAIR AND TRANSPARENT REIMBURSEMENT RATES; TO ENSURE PARITY OF HEALTHCARE SERVICES; TO AMEND THE BILLING IN THE BEST INTEREST OF PATIENTS ACT; AND TO DECLARE AN EMERGENCY.

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

SECTION 1. DO NOT CODIFY. Legislative findings and intent.

(a) The General Assembly finds that:

(1) Disparities in the reimbursement rates for medical and imaging services performed at hospital-based outpatient departments and other licensed outpatient healthcare facilities can create barriers to competition, reduce patient access to cost-effective care, and impose unnecessary financial burdens on healthcare providers providing medical and outpatient imaging services outside of hospital facilities;

(2) In Ark. Blue Cross & Blue Shield v. Freeway Surgery Ctr.,

2024 Ark. App. 540, the Arkansas Court of Appeals interpreted Arkansas law in a manner that permits insurers to reimburse licensed ambulatory surgical centers at rates lower than those paid to hospital-based facilities for the same outpatient services despite the clear legislative intent to ensure reimbursement on an equal basis;

(3) The interpretation in Ark. Blue Cross & Blue Shield v. Freeway Surgery Ctr., 2024 Ark. App. 540. undermines competition in the healthcare marketplace, disincentivizes cost-efficient alternatives to hospital-based care, and imposes financial hardships on providers operating in nonhospital settings; and

(4) Transparency in reimbursement methodologies will promote fairness in the healthcare marketplace and ensure that insurers comply with existing state laws governing provider reimbursement.

(b) It is the intent of the General Assembly in enacting this act to:

(1) Ensure fair and equitable reimbursement rates for medical or imaging services performed at licensed ambulatory surgical centers, outpatient psychiatric centers, and outpatient imaging facilities;

(2) Amend the law to clarify that insurers shall not reimburse licensed ambulatory surgical centers at rates lower than those applied to hospital-based outpatient departments for equivalent healthcare services, thereby making the holding in Ark. Blue Cross & Blue Shield v. Freeway Surgery Ctr., 2024 Ark. App. 540, no longer applicable;

(3) Reaffirm the requirement that insurers establish fair, transparent, and nondiscriminatory reimbursement methodologies that ensure insurers reimburse all licensed healthcare facilities on an equal basis for performing the same medical, surgical, or imaging services under § 23-79-115; and

(4) Require insurers to:

(A) Reimburse licensed ambulatory surgical centers, outpatient imaging providers' facilities or centers, and outpatient psychiatric centers on an equal basis as hospitals and hospital-based outpatient departments for the same medical, surgical, and imaging services;

(B) Disclose the insurer's reimbursement methodologies and rates to contracted providers; and

(C) Ensure that reimbursement rates for services at ambulatory surgical centers, outpatient imaging providers facilities or

centers, and outpatient psychiatric centers:

(i) Are not set below ninety percent (90%) of the average hospital-based outpatient rate for the same service in the applicable county or otherwise in county with the closest hospital facility; and

(ii) Apply retroactively to all reimbursement claims and contracts in effect as of the effective date of this act, including any pending claims, disputes, or litigation concerning the reimbursement of services provided by ambulatory surgical centers, outpatient imaging providers' facilities or centers, and outpatient psychiatric centers.

SECTION 2. Arkansas Code § 23-79-101 is amended to read as follows:

23-79-101. Definitions.

As used in this chapter:

(1) "Excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(A) Benefits not subject to requirements, including without limitation:

(i) Coverage only for accident or disability income insurance, or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance; and

(vii) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(B) Limited-scope dental or vision benefits;

(C) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(D) Coverage only for a specified disease or illness;

(E) Hospital indemnity or other fixed indemnity insurance; and

(F) Medicare supplemental health insurance as defined

under section 1882(g)(1) of the Social Security Act, 42 U.S.C. § 1395ss(g)(1), coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq., and similar supplemental coverage;

(2) "Hospital-based outpatient department" means a healthcare facility that provides outpatient services to a patient at an on-site hospital-operated outpatient clinic or other hospital-affiliated clinic location;

(3) "Hospital-based outpatient department service" means a healthcare service paid with an insurer's payment system to a hospital for outpatient services, including without limitation imaging, surgery, and medical services, that are performed at a hospital-based outpatient department;

(4) "Outpatient imaging facility or center" means a healthcare facility or provider that provides diagnostic and advanced imaging services to patients and uses Current Procedural Terminology codes 70010–79999 to bill for the facility component of imaging services;

(5) "Policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements, and papers made a part thereof; ~~and~~

~~(3)(A)~~(6)(A) "Premium" is the consideration for insurance, by whatever name called.

(B) Any assessment, or any membership, policy, survey, inspection, service, or similar fee or charge in consideration for a policy is deemed part of the premium; and

(7) "The same or similar healthcare service" means a healthcare service provided to a patient identified by the same or a substantially similar Current Procedural Terminology code developed by the American Medical Association.

SECTION 3. Arkansas Code § 23-79-115 is amended to read as follows:

23-79-115. Entitlement notwithstanding policy provisions — Services performed by outpatient centers.

(a)(1)(A) ~~Notwithstanding any provisions of any individual or group accident and health insurance policy, or any provision of a policy, contract, plan, or agreement covering hospital or medical services, in cases in which the policy, contract, plan, or agreement provides for payment or~~

~~reimbursement for any healthcare service provided by hospitals or related facilities~~ When an insurer under a policy, contract, plan, or agreement agrees to pay or reimburse for a healthcare service provided at or by a hospital or related facility as defined in § 20-9-201 or § 20-10-213, the healthcare provider, healthcare facility, or other person entitled to payment or reimbursement for any healthcare services at a licensed ambulatory surgery center, outpatient surgery center, or outpatient imaging facility or center under the policy, contract, plan, or agreement and is entitled to ~~payment or reimbursement on an equal basis for the service when the service is provided by facilities licensed as outpatient surgery centers under §§ 20-9-214 and 20-9-215~~ be payment or reimbursement at a rate that is no less than ninety percent (90%) of the rate paid to a hospital or related facility for the same or similar healthcare service, as identified by the its designated Current Procedural Terminology code.

(B) This subdivision (a)(1) applies notwithstanding any provision of:

(i) An individual or group accident and health insurance policy;

(ii) A policy, contract, plan, or agreement covering hospital or medical services;

(iii) A network participation agreement; or

(iv) An agreement between an insurer and a healthcare provider.

(2) ~~This subsection~~ Subdivision (a)(1) of this section applies to insurance policies and hospital service corporation contracts that are delivered or issued for delivery in this state more than one hundred twenty (120) days after July 6, 1977, and to such other contracts, plans, or agreements that are entered into or effectuated in this state more than one hundred twenty (120) days after July 6, 1977, including without limitation network participation agreements or any agreement between an insurer and a healthcare provider.

(b)(1)(A) ~~Notwithstanding any provisions of any individual or group accident and health insurance policy, or any provision of a policy, contract, plan, or agreement covering hospital or medical services, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any healthcare service provided by hospitals or related~~

~~facilities~~ When an insurer under a policy, contract, plan, or agreement agrees to pay or reimburse for a healthcare service provided at or by a hospital or related facility as defined in § 20-9-201 or § 20-10-213, the healthcare provider, healthcare facility, or other ~~the~~ person entitled to payment or reimbursement ~~or services~~ for any healthcare services at a licensed ambulatory surgery center, outpatient surgery center, or outpatient imaging facility or center under the policy, contract, plan, or agreement is entitled to ~~payment or reimbursement on an equal basis for the service when the service is provided by facilities licensed as outpatient psychiatric centers under §§ 20-9-214 and 20-9-215~~ be paid or reimbursed at a rate that is no less than ninety percent (90%) of the rate paid to a hospital or related facility for the same or similar healthcare service, as identified by the its designated Current Procedural Terminology code in the same geographic area.

(B) This subdivision (b)(1) shall apply notwithstanding any provision of:

(i) An individual or group accident and health insurance policy;

(ii) A policy, contract, plan, or agreement covering hospital or medical services;

(iii) A network participation agreement; or

(iv) An agreement between an insurer and a healthcare provider.

(2) ~~This subsection~~ Subdivision (b)(1) of this section applies to insurance policies and hospital service corporation contracts that are delivered or issued for delivery in this state more than one hundred twenty (120) days after July 20, 1979, and to such other contracts, plans, or agreements that are entered into or effectuated in this state more than one hundred twenty (120) days after July 20, 1979, including without limitation network participation agreements or any agreements between an insurer and a healthcare provider.

(c) The purpose of this section is to ensure that a healthcare provider, a healthcare facility, or other person entitled to payment or reimbursement for any healthcare service from an insurer is paid or reimbursed at a rate no more than ten percent (10%) less than the amount paid or reimbursed to a hospital for the same or similar healthcare service, as

identified by its designated Current Procedural Terminology code, in the same geographic area if the healthcare service is performed at an ambulatory surgical center, outpatient surgical center, outpatient imaging center or facility, or outpatient psychiatric center, subject to the following:

(1)(A) An insurer may consider and apply the Patient Protection Act of 1995, § 23-99-201 et seq., and § 23-99-801 et seq. when establishing a rate for payment or reimbursement for a healthcare service that is provided at an outpatient surgery center licensed under §§ 20-9-214 and 20-9-215, an outpatient imagining facility or center, and an outpatient psychiatric center if the insurer annually certifies compliance with this section and § 23-99-204 with the State Insurance Department.

(B) The certification required under subdivision (c)(1)(A) of this section shall include the following information:

(i)(a) The insurer's methodology for determining payment or reimbursement rates to include the factors, mathematical computations, and weights considered by the insurer in determining each individual healthcare provider's reimbursement rate.

(b) The factors under subdivision (c)(1)(B)(i)(a) of this section shall include without limitation:

(1) The healthcare provider type;

(2) Geographic location;

(3) Complexity of the medical service;

(4) Healthcare provider's contractual agreement;

(5) Quality measures, such as patient satisfaction, clinical outcomes, and adherence to clinical guidelines or performance metrics;

(6) Application of utilization control measures, such as prior authorization or case management, to ensure services are medically necessary and cost-effective;

(7) Influence of service volume or case-load in determining the reimbursement rate;

(8) Reimbursement adjustments to account for the risk profiles of the healthcare provider's patient population, such as adjusting for high-risk patient groups requiring more intensive care; and

(9) Any other factors deemed pertinent

by the Insurance Commissioner;

(ii)(a) A schedule of reimbursement rates for each healthcare provider with which the insurer maintains an agreement referenced in subsections (a) and (b) of this section based on the class of healthcare provider and geographic location, a copy of which shall also be provided to applicant healthcare providers.

(b) The amount of information included on a schedule of reimbursement rates under subdivision (c)(1)(B)(ii)(a) of this section shall be comprehensive enough to enable the healthcare provider to determine the manner in which the healthcare provider is paid and the amount that a healthcare provider will be paid under the contract for the healthcare provider's services.

(c) The schedule of reimbursement rates or other information submitted to a healthcare provider under this section shall include a description of the processes and factors that may affect the actual amount paid to the healthcare provider, including without limitation copayments, coinsurance, deductibles, risk-sharing arrangements, and liability of third parties.

(d) If an actual payment for the procedures cannot be ascertained from the fee schedule or other information submitted to a healthcare provider under this section, the insurer shall provide an explanation of the methodology used to determine actual payment for procedures frequently performed by the healthcare provider that involve combinations of services or payment codes, such as the relative value unit system and conversion factor, the percentage of Medicare payment system, or percentage of billed charges.

(e) As applicable, the methodology disclosure provided for in this section shall include the name of any relative value system, the version, edition, or publication date of the relative value system, and any applicable conversion to the relative value system or modification to the relative value system to account for the geographic location in which the healthcare provider practices;

(iii) An analysis of any disparity in reimbursement rates among healthcare providers; and

(iv) If an insurer employs or utilizes a standard deviation in its comparative reimbursement analysis, a detailed narrative

explaining the reason for the disparity and the mathematical basis for which the disparate reimbursement rates were derived.

(2) A healthcare provider who contracts with an insurer shall be entitled to receive the information contained in subsection (c) of this section relating to the healthcare provider's agreement with the insurer if the healthcare provider is required to first execute a confidentiality agreement to ensure that the insurer's confidential or proprietary information remains confidential.

(3)(A) An insurer shall not establish a payment or reimbursement rate for a healthcare service that is less than ninety percent (90%) of the average reimbursement rate for the same or similar healthcare service, as identified by its designated Current Procedural Terminology code, paid to hospital-based outpatient departments, in the county where the ambulatory surgical center, outpatient surgery center, outpatient imaging facility or center, or outpatient psychiatric center is licensed.

(B) If a hospital or hospital-based outpatient department is not located in the county where the ambulatory surgical center, outpatient surgical center, outpatient imaging facility or center, or outpatient psychiatric center is located, the average reimbursement rate for the services provided by the ambulatory surgical center, outpatient surgical center, outpatient imaging facility or center, or outpatient psychiatric center is determined by the nearest county where a hospital or hospital-based outpatient department operates; and

(3)(A) An insurer shall not attempt to reduce competition in the healthcare marketplace by limiting coverage for outpatient services performed by nonhospital facilities services.

(B) An insurer shall cover services performed at ambulatory surgical centers, outpatient surgical centers, outpatient imaging facilities or centers, and outpatient psychiatric centers, if those services are covered under the insurer's contracts for hospital-based outpatient department payment to hospitals in this state.

(d)(1) This section shall not be waived by contract.

(2) An agreement or other arrangement that violates this subchapter is void.

(e)(1) The Insurance Commissioner:

(i) Shall enforce this subchapter; and

(ii) May promulgate rules to implement the requirements of this subchapter as needed.

(2) All remedies, penalties, and authority granted to the commissioner under the Trade Practices Act, § 23-66-201 et seq., including the award of restitution and damages, shall be available to the commissioner for the enforcement of this subchapter.

(f) A violation of this section is a deceptive act, as defined by the Trade Practices Act, § 23-66-201 et seq. and § 4-88-101 et seq., except that the statute of limitations for private causes of action against an insurer by a healthcare provider shall be five (5) years for a violation of this section.

SECTION 4. Arkansas Code Title 23, Chapter 99, Subchapter 15, is amended to add an additional section to read as follows:

23-99-1505. Prohibition on pricing increases or reduction of fee schedules.

(a) An insurer shall not increase cost-sharing, premiums, or other fees, including without limitation per-month payments, on an enrollee, employer, or any other entity that is responsible for payment of cost-sharing, premiums, or other fees, including without limitation per-month payments, on behalf of an enrollee for healthcare services under a health benefit plan or lower existing reimbursement rates for existing hospital inpatient or outpatient care or to nonhospital outpatient services or facilities or healthcare providers unless each of the following conditions are met:

(1) The insurer's excess of capital over its mandatory control level RBC, as defined in § 23-63-1302, is less than sixty-five percent (65%);

(2) The insurer's medical loss ratio is ninety percent (90%) or greater on clinical services and quality improvement; and

(3) The proposed increase receives the approval of the Insurance Commissioner after the commissioner confirms compliance with this section and § 23-79-115.

(b)(1) For purposes of this section, the costs associated with carrying enrollee medical debt is an administrative cost for purposes of calculating the medical loss ratio.

(2) However, clinical services shall not include any cost-

sharing.

SECTION 5. DO NOT CODIFY. Severability.

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

SECTION 6. DO NOT CODIFY. Retroactivity.

This act shall apply retroactively to a reimbursement claim and contract in effect as of the effective date of this act, including any pending claims, disputes, or litigation concerning the reimbursement of services provided by a ambulatory surgical center, outpatient imaging provider, facility or center, and outpatient psychiatric center.

SECTION 7. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that the absence of adequate statutory enforcement of Arkansas Code § 23-79-115 has resulted in arbitrary and discriminatory reimbursement practices that threaten the financial viability of ambulatory surgical centers and outpatient psychiatric centers; that without immediate intervention by the General Assembly to pass legislation to clarify enforcement, discriminatory reimbursement practices will continue to restrict patient access to cost-effective healthcare providers causing irreparable harm to Arkansas residents; and that this act is immediately necessary because current Arkansas law does not sufficiently address transparency in healthcare pricing, the absence of proper enforcement of health insurer reimbursement rate laws has allowed health insurers to ignore the application of Arkansas Code § 23-79-115 that has been the law since November 17, 1979, that any willing provider laws are subordinate to the requirements of Arkansas Code § 23-79-115 and proper adherence to pay-parity statutes ensures patient access to healthcare providers of their choice, and that it is immediately necessary to protect against deceptive insurance practices that harm the delivery of healthcare and reimbursement for healthcare services in Arkansas. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the

public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.