

INTERIM STUDY PROPOSAL 2025-019

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2
3 State of Arkansas
4 95th General Assembly
5 Regular Session, 2025

As Engrossed: S4/8/25

A Bill

SENATE BILL 626

6
7 By: Senator Irvin
8 By: Representative L. Johnson

9 Filed with: Senate Committee on Insurance and Commerce
10 pursuant to A.C.A. §10-3-217.

11 **For An Act To Be Entitled**

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

20
21
22 **Subtitle**

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

28
29 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

30
31 SECTION 1. DO NOT CODIFY. Legislative findings and intent.

32 (a) The General Assembly finds that:

33 (1) Arkansas's healthcare providers are at a significant
34 disadvantage as a result of national reimbursement methodologies and receive
35 some of the lowest commercial rates in the country;

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

1 2024 Ark. App. 540, the Arkansas Court of Appeals interpreted Arkansas law in
2 a manner that permits insurers to reimburse licensed ambulatory surgical
3 centers at rates lower than those paid to hospital-based facilities for the
4 same outpatient services despite the clear legislative intent to ensure
5 reimbursement on an equal basis;

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

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

14 (b) It is the intent of the General Assembly to:

15 (1) Ensure fair and equitable reimbursement rates for healthcare
16 clinics, hospitals, medical or imaging services performed at licensed
17 ambulatory surgical centers, outpatient psychiatric centers, and outpatient
18 imaging facilities; and

19 (2) Require insurers to:

20 (A) Reimburse healthcare clinics, hospitals, medical or
21 imaging services performed at licensed ambulatory surgical centers,
22 outpatient psychiatric centers, and outpatient imaging facilities fairly and
23 equitably;

24 (B) Disclose the insurer's reimbursement methodologies;
25 and

26 (C) Ensure minimum reimbursement rates for healthcare
27 clinics, hospitals, medical or imaging services performed at licensed
28 ambulatory surgical centers, outpatient psychiatric centers, and outpatient
29 imaging facilities.

30
31 *SECTION 2. Arkansas Code Title 23, Chapter 99, is amended to add an*
32 *additional subchapter to read as follows:*

33 *Subchapter 20 – Minimum Reimbursement Rates for Healthcare Services*

34
35 *23-99-2001. Definitions.*

36 *As used in this subchapter:*

1 (1) "Adjoining states" means Louisiana, Mississippi, Missouri,
2 Oklahoma, Tennessee, and Texas;

3 (2) "Ambulatory surgery center" means an entity certified by the
4 Department of Health as an ambulatory surgery center that operates for the
5 purpose of providing surgical services to patients;

6 (3)(A) "Equivalent Medicare reimbursement" means the amount,
7 based on prevailing reimbursement rates and methodologies, that a healthcare
8 provider or health system is entitled to for healthcare services.

9 (B)(i) "Equivalent Medicare reimbursement" includes
10 services that are not covered by Medicare or are set locally by Medicare
11 contractors.

12 (ii) Services under this subdivision (3) will be
13 priced at the healthcare provider's overall prevailing Medicare reimbursement
14 collection-to-charge ratio;

15 (4)(A) "Health benefit plan" means an individual, blanket, or
16 group plan, policy, or contract for healthcare services issued, renewed, or
17 extended in this state by a healthcare insurer.

18 (B) "Health benefit plan" includes any group plan, policy,
19 or contract for healthcare services issued outside this state that provides
20 benefits to residents of this state.

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

22 (i) A plan that provides only dental benefits;
23 (ii) A plan that provides only eye and vision
24 benefits;

25 (iii) A disability income plan;

26 (iv) A credit insurance plan;

27 (v) Insurance coverage issued as a supplement to
28 liability insurance;

29 (vi) Medical payments under an automobile or
30 homeowners' insurance plan;

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

34 (viii) A plan that provides only indemnity for
35 hospital confinement;

36 (ix) An accident-only plan;

1 (x) A specified disease plan;
2 (xi) A policy, contract, certificate, or agreement
3 offered or issued by a healthcare insurer to provide, deliver, arrange for,
4 pay for, or reimburse any of the costs of healthcare services, including
5 pharmacy benefits, to an entity of the state under § 21-5-401 et seq;

6 (xii) A qualified health plan that is a health
7 benefit plan under the Patient Protection and Affordable Care Act, Pub. L.
8 No. 111-148, and purchased on the Arkansas Health Insurance Marketplace
9 created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et
10 seq., for an individual up to four hundred percent (400%) of the federal
11 poverty level;

12 (xiii) A health benefit plan provided by a trust
13 established under § 14-54-104 to provide benefits, including accident and
14 health benefits, death benefits, dental benefits, and disability income
15 benefits;

16 (xiv) A long-term care insurance plan; or

17 (xv) A health benefit plan provided by an
18 institution of higher education;

19 (5) "Health system" means an organization that owns or operates
20 more than one (1) hospital;

21 (6)(A) "Healthcare insurer" means an entity that is authorized
22 by this state to offer or provide health benefit plans, policies, subscriber
23 contracts, or any other contracts of a similar nature that indemnify or
24 compensate a healthcare provider for the provision of healthcare services.

25 (B) "Healthcare insurer" includes without limitation:

26 (i) An insurance company;

27 (ii) A health maintenance organization;

28 (iii) A hospital and medical service corporation;

29 and

30 (iv) An entity that provides or administers a self-
31 funded health benefit plan.

32 (C) "Healthcare insurer" does not include:

33 (i) The Arkansas Medicaid Program;

34 (ii) The Arkansas Health and Opportunity for Me
35 Program under the Arkansas Health and Opportunity for Me Act of 2021, § 23-
36 61-1001 et seq., or any successor program;

- 1 (iii) A provider-led Arkansas shared savings entity;
- 2 (iv) An entity that offers a plan providing health
- 3 benefits to state and public school employees under § 21-5-401 et seq.; or
- 4 (v) An entity that offers a plan providing health
- 5 benefits to an institution of higher education;

6 (7) "Healthcare provider" means:

- 7 (A) A hospital;
- 8 (B) A health system;
- 9 (C) A physician;
- 10 (D)(i) A physician extender.
- 11 (ii) A physician extender includes without
- 12 limitation:
- 13 (a) A physician assistant who is licensed in
- 14 this state;
- 15 (b) A nurse practitioner who is licensed in
- 16 this state;
- 17 (c) An advanced practice nurse who is licensed
- 18 in this state; and
- 19 (d) A certified midwife who is licensed in
- 20 this state;
- 21 (E) A licensed ambulatory surgery center; and
- 22 (F) An outpatient facility that performs healthcare
- 23 services, including without limitation primary care clinics, urgent care
- 24 centers, specialty clinics, dialysis centers, and imaging centers;

25 (8) "Healthcare service" means a service or good that is
26 provided for the purpose of or incidental to the purpose of preventing,
27 diagnosing, treating, alleviating curing, or healing human illness, disease,
28 condition, disability, or injury;

29 (9) "Hospital" means a healthcare facility licensed as a
30 hospital by the Division of Health Facilities Services under § 20-9-213;

31 (10) "Minimum reimbursement level" means the minimum ratio of
32 reimbursement to equivalent Medicare reimbursement that a healthcare provider
33 or health system is entitled to by a healthcare insurer for healthcare
34 services;

35 (11) "Outpatient imaging facility" means a healthcare facility
36 or provider that provides diagnostic and advanced imaging services to

1 patients and uses Current Procedural Terminology codes 70010–79999 to bill
2 for the facility component of imaging services;

3 (12) "Physician" means a person authorized or licensed to
4 practice medicine under the Arkansas Medical Practices Act, § 17-95-201 et
5 seq., § 17-95-301 et seq., and § 17-95-401 et seq.; and

6 (13) "Reimbursement rate" means the amount that a healthcare
7 provider is entitled to receive for healthcare services.

8
9 23-99-2002. Minimum reimbursement level.

10 (a)(1) A health benefit plan shall reimburse a healthcare provider
11 that provides a healthcare service the minimum reimbursement level for the
12 healthcare service as determined by the Insurance Commissioner.

13 (2) The commissioner is not required to establish a minimum
14 reimbursement level for each healthcare service.

15 (3) The minimum reimbursement level shall be established at the
16 healthcare provider's contract level based on the healthcare provider's
17 specific compliment of services.

18 (b) The minimum reimbursement level under subdivision (a)(1) of this
19 section shall be phased in according to the schedule below:

20 (1) On or after January 1, 2026, forty-five percent (45%);

21 (2) On or after January 1, 2027, fifty-five percent (55%);

22 (3) On or after January 1, 2028, sixty-five percent (65%);

23 (4) On or after January 1, 2029, seventy-five percent (75%); and

24 (5) On or after January 1, 2030, one hundred percent (100%).

25 (c)(1) The commissioner shall determine the minimum reimbursement
26 level for a healthcare service by calculating the weighted average ratio of
27 commercial prices as a percentage of Medicare reimbursement for the
28 healthcare service in adjoining states as derived from the RAND Corporation's
29 Prices Paid to Hospitals by Private Plans findings as adopted by rule of the
30 commissioner.

31 (2) If the RAND Corporation's Prices Paid to Hospitals by
32 Private Plans findings are discontinued, delayed, or deemed unsuitable by the
33 commissioner, the commissioner shall compute an adjusted ratio of commercial
34 prices as a percentage of Medicare by applying a factor of the annual change
35 in the Consumer Price Index: Medical Care, commonly known as the "medical
36 care index", published by the United States Bureau of Labor Statistics and

1 adopted by rule of the commissioner to the weighted average increase of
2 Medicare reimbursement for a healthcare provider to the most recently
3 published minimum reimbursement level.

4 (d) Beginning September 1, 2025, the commissioner shall publish
5 annually on the State Insurance Department's website the minimum
6 reimbursement level as determined under subsection (c) of this section.

7
8 23-99-2003. Disclosures.

9 (a)(1) A healthcare insurer shall document compliance with this
10 subchapter for each healthcare provider.

11 (2) A healthcare insurer shall include documentation of
12 compliance required in subdivision (a)(1) of this section for each health
13 benefit plan offered by the healthcare insurer to a healthcare provider.

14 (b)(1) A healthcare insurer shall disclose to each contracted
15 healthcare provider summary documentation, including the supporting detailed
16 calculations and assumptions.

17 (2) The summary documentation under subdivision (b)(1) of this
18 section shall be made available to:

19 (A) The contracted healthcare provider before the
20 execution or renewal of a contract and within fifteen (15) days of a formal
21 request; and

22 (B) The Insurance Commissioner within fifteen (15) days of
23 a formal request.

24
25 23-99-2004. Enforcement.

26 (a) A dispute under this subchapter shall be filed with the Insurance
27 Commissioner.

28 (b)(1) After notice and opportunity for a hearing, if a healthcare
29 insurer or a health benefit plan is found to have violated this subchapter,
30 the commissioner may revoke or suspend the authority of the healthcare
31 insurer or health benefit plan to do business in this state.

32 (2) The commissioner shall rule on a dispute within sixty (60)
33 days.

34 (c) A healthcare insurer or health benefit plan that has violated this
35 subchapter shall be required to repay the healthcare provider all amounts in
36 violation of this subchapter plus eight percent (8%) interest and five

1 percent (5%) in administrative fees, inclusive of amounts otherwise due from
2 the patient.

3
4 23-99-2005. Prohibition on pricing increases.

5 (a) Before a healthcare insurer's implementation of an increase in
6 premium rates, cost sharing, or per-member-per-month costs or payments for
7 rates or insurance policies that are required to be reviewed by the Insurance
8 Commissioner under §§ 23-79-109 and 23-79-110, the commissioner shall
9 consider the following additional factors in his or her review:

10 (1) The extent to which the healthcare insurer's RBC level as
11 defined in § 23-63-1302 is less than six hundred fifty percent (650%); and

12 (2)(A) To the extent permitted by federal law, whether the
13 healthcare insurer's medical loss ratio is greater than eighty-five percent
14 (85%) on clinical services and quality improvement.

15 (B) The calculation of medical claims and quality
16 improvements for a healthcare insurer's medical loss ratio under subdivision
17 (a)(2)(A) of this section should exclude:

18 (i) Any performance-based compensation, bonus, or
19 other financial incentive paid directly or indirectly to a contracting entity
20 employee, affiliate, contractor, or other entity or individual;

21 (ii) Any expense associated with carrying enrollee
22 medical debt; and

23 (iii) Cost sharing.

24 (b) A healthcare insurer in the fully insured group market shall
25 consider the factors in subsection (a) of this section before implementing an
26 increased premium rate, cost sharing, or enrollee per-member-per-month fee.

27
28 23-99-2006. Rules.

29 The Insurance Commissioner may promulgate rules to implement and
30 enforce this subchapter.

31
32 23-99-2007. Remedies and penalties.

33 (a) This subchapter shall not be waived by contract.

34 (b) An agreement or other arrangement that violates this subchapter is
35 void.

36 (c) All remedies, penalties, and authority granted to the Insurance

1 Commissioner under the Trade Practices Act, § 23-66-201 et seq., including
2 the award of restitution and damages, shall be made available to the
3 commissioner for the enforcement of this subchapter.

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

9
10 SECTION 3. DO NOT CODIFY. Severability.

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

16
17 SECTION 4. DO NOT CODIFY. Retroactivity.

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

23
24 SECTION 5. EMERGENCY CLAUSE. It is found and determined by the
25 General Assembly of the State of Arkansas that the absence of adequate
26 statutory enforcement of Arkansas Code § 23-79-115 has resulted in arbitrary
27 and discriminatory reimbursement practices that threaten the financial
28 viability of ambulatory surgical centers and outpatient psychiatric centers;
29 that without immediate intervention by the General Assembly to pass
30 legislation to clarify enforcement, discriminatory reimbursement practices
31 will continue to restrict patient access to cost-effective healthcare
32 providers causing irreparable harm to Arkansas residents; and that this act
33 is immediately necessary because current Arkansas law does not sufficiently
34 address transparency in healthcare pricing, the absence of proper enforcement
35 of health insurer reimbursement rate laws has allowed health insurers to
36 ignore the application of Arkansas Code § 23-79-115 that has been the law

1 since November 17, 1979, that any willing provider laws are subordinate to
2 the requirements of Arkansas Code § 23-79-115 and proper adherence to pay-
3 parity statutes ensures patient access to healthcare providers of their
4 choice, and that it is immediately necessary to protect against deceptive
5 insurance practices that harm the delivery of healthcare and reimbursement
6 for healthcare services in Arkansas. Therefore, an emergency is declared to
7 exist, and this act being immediately necessary for the preservation of the
8 public peace, health, and safety shall become effective on:

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

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

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

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16 */s/ Irvin*

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19 Referred requested by the Arkansas Senate

20 Prepared by: ANS/AMS

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