BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF ARKANSAS

IN THE MATTER OF LIMITED SCOPE MARKET CONDUCT EXAMINATION REPORTS/ADOPTION ORDERS (AID Orders No. 2007-077, 2007-078 and 2007-079)

ARKANSAS SURGICAL HOSPITAL — PETITIONER

ARKANSAS BLUE CROSS BLUE SHIELD, QCA HEALTH PLAN, INC. ("QUALCHOICE" A/K/A "QCA") UNITED HEALTHCARE OF ARKANSAS, INC. AND UNITED HEALTHCARE INSURANCE COMPANY — RESPONDENTS

THE SURGICAL HOSPITAL OF JONESBORO, LLC, OUACHITA REGIONAL DIAGNOSTIC & SURGERY CENTER OF HOT SPRINGS, INC. D/B/A HEALTHPARK HOSPITAL, SISTERS OF MERCY HEALTH SYSTEM and ARKANSAS HOSPITAL ASSOCIATION — INTERVENORS

A.I.D. NO. 2008-064

ORDER

From April 14, 2008, to April 17, 2008, an administrative hearing ("Hearing") was held before Hearing Officer and Arkansas Insurance Commissioner, Julie Benafield Bowman ("Commissioner"), in the Hearing Room of the Arkansas Insurance Department ("Department") to consider a January 30, 2008, Petition ("Petition"), filed at the Department by the Arkansas Surgical Hospital ("Petitioner"). The Petition requested, *inter alia*, an administrative hearing challenging or appealing various aspects of three (3) Adoption Orders issued by the Commissioner on December 14, 2007, in Arkansas Insurance Department Order Nos. 2007-077, 2007-078 and 2007-079 ("Adoption Orders").

Present on behalf of the Department were Booth Rand, Chief Counsel, Jay Morgan, Deputy Commissioner/General Counsel, and Robert Alexander, Associate Counsel. Representing the Petitioner were Charles Gall and James Bowen, admitted *pro hac vice*, Sam Perroni, and Shelly Hogan. Present on behalf of Arkansas Blue Cross and Blue Shield ("ABCBS") were Frank B. Sewall, Robert D. Ridgeway, Jr., and Jacqueline M. Saue, admitted *pro hac vice*. Present on behalf of United HealthCare of Arkansas, Inc. and United HealthCare Insurance Company (hereafter "United") were Allan Gates, Nick Thompson, and John Harriman. Present on behalf of QCA Health Plan, Inc. ("QCA") were John R. Tisdale, Kathryn Irby, and Adrienne Jung. Present on behalf of Intervenors Ouachita Regional Diagnostic & Surgery Center of Hot Springs, Inc. d/b/a HealthPark Hospital ("HealthPark") and The Surgical Hospital of Jonesboro, LLC ("Surgical Hospital of Jonesboro") (hereafter, "Petitioner Intervenors") were Thomas B. Staley and William T. Marshall. Appearing for Intervenor Sisters of Mercy Health System were William Allen and Kevin M. Lemley. Present on behalf of Intervenor Arkansas Hospital Association ("AHA") was Elisa M. White. Present on behalf of St. Vincent Health System ("St. Vincent") was Stephen Jones.

From the testimony of witnesses and other evidence of record adduced at the public hearing (including exhibits filed in connection therewith) the Commissioner finds as follows:

PROCEDURAL HISTORY

The Petitioner, Arkansas Surgical Hospital, is a hospital located in North Little Rock, Arkansas. The Petitioner is licensed by the State of Arkansas to operate as a

hospital in this state and provides hospital services primarily in four (4) areas: orthopedics, spine, cosmetic reconstruction, and pain management. The Petitioner is certified to operate as a hospital by the Centers For Medicare and Medicaid Services ("CMS") and is an accredited and certified hospital by the Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission").

On January 29, 2007, the Petitioner filed a written complaint ("Complaint") at the Department against three health insurers: QCA, United, and ABCBS (hereafter, collectively, the "Health Insurers") requesting, *inter alia*, that the Department obtain and compare the Petitioner's in-network hospital "reimbursement" rates with other in-network member hospitals within each respective insurer's network. The Petitioner stated in its Complaint that, if the "reimbursement" rates for the procedures were in fact different, the Department should require that the insurers pay the affected hospitals the incremental amount necessary to correct discriminatory payment rates for all cases served in-network retroactive to the contract beginning date. At the time of the filing of the Complaint, the Petitioner was a contracted "in-network" hospital facility within each of the insurer's networks. As the basis for the Complaint, the Petitioner cited Arkansas's "Any Willing Provider" law (Ark. Code Ann. §23-99-201 et seq., and Ark. Code Ann. §23-99-801 et seq.).

On or about February 7, 2007, the Department forwarded the Complaint to each of the Health Insurers for a response. In the responses to the Complaint by the Health Insurers, each insurer denied that its payment rates to the Petitioner violated the "Any Willing Provider" law. After receipt of the responses by the Department, on or about March 26, 2007, the Department requested each Health Insurer to respond in writing to a

request for information which asked each insurer to describe the current manner of "reimbursement" chosen by three (3) hospitals operating in this state: Baptist Hospital, St. Vincent, and the Surgical Hospital of Jonesboro, LLC. The request (hereafter, the "Survey") asked each insurer to describe all of the criteria, formula, or factors which are involved in the calculation of the "reimbursement" amounts for the following in-patient procedures: (1) DRG 500 (Back and Neck Procedures); (2) DRG 520 (Cervical Spinal Fusion without CC); and (3) DRG 544 (Major Joint Replacement or reattachment of lower extremity). The Survey asked for similar information for the following out-patient procedures: (1) CPT#63030 (Excision intervertebral disc); (2) CPT#29881 (Excision semilunar cartilage of knee); and (3) CPT#29827 (Rotator cuff repair). DRG is the abbreviation for "diagnosis-related grouping" and is a method of classifying hospital patients by similar diagnosis, procedure, sex, and discharge status. CPT is an abbreviation for "current procedural terminology" and is simply a code which describes a specific medical, surgical, and diagnostic service.

During the course of these Limited Scope Market Conduct Examinations, each Health Insurer answered the Survey and follow-up requests made by the Department. On October 24, 2007, the Department issued three (3) separate examination reports (the "Reports"), one for each Health Insurer, discussing the payment amount differences and the legality of the differences under the "Any Willing Provider" law. The Reports concluded that for the procedures and payments surveyed the Petitioner was paid less for each procedure than the other surveyed in-network hospitals within each of the insurer's networks except in two (2) instances. These were when the Petitioner's payment amounts were compared with those of Surgical Hospital of Jonesboro (or HealthPark in the case of

United's network) and when its out-patient payment amounts were compared with the amounts received by the other surveyed member hospitals within the ABCBS network. Outside of those exceptions, the Petitioner was paid less for the same procedure within each of the insurer's provider networks, at least according to the six (6) procedures surveyed. According to the Reports, although the exact terminologies differed among each Health Insurer, the payment differences with Petitioner, except in the case of the Surgical Hospital of Jonesboro (and HealthPark in the case of United's network), derived from the fact that the other surveyed hospitals were assigned different (higher) "base rate" modifiers to the DRG "case weights" for each of the procedures.

The Reports then reviewed whether the payment differences operated as "reduced reimbursement" constituting improper monetary penalties in Ark. Code Ann. §23-99-204(a)(1)(B)(ii) under the "Any Willing Provider" law and whether the violations were "saved" or excused as measures by the insurer to control costs and maintain quality under Ark. Code Ann. §23-99-206 and Ark. Code Ann. §23-99-204(b). For each Health Insurer surveyed, the Reports concluded that there was no connection between the payment differences, and cost and quality factors of the Petitioner performing such procedures. Each Report, however, concluded that there was no violation of the "Any Willing Provider" law because there was no evidence that a beneficiary's choice was affected by the payment differences. The Reports indicated that should there exist direct or indirect affects on beneficiary choice due to the payment differences, such as from a medical provider's termination of its network contract with a health insurer, or when such differences diminish the quality of care provided to the beneficiary, there would exist violations of the "Any Willing Provider" law. The Reports did not make a distinction

between the terms “reimbursement” and “payment” under §23-99-204(a); the Reports did not separately analyze whether the payment differences violated Ark. Code Ann. §23-99-204(a)(3); and the Reports concluded that under Ark. Code Ann. §23-99-203(d)(1)-(28) and Ark. Code Ann. §23-99-802(4)(A)-(DD) there exists no separate class for “specialty hospitals,” but instead there exists one class of “hospitals” in Ark. Code Ann. §23-99-203(d)(11) and Ark. Code Ann. §23-99-802(4)(K).

On December 14, 2007, the Commissioner issued three (3) Adoption Orders related to the above described Reports: (1) *“In The Matter Of A Limited Scope Market Conduct Examination Of United Healthcare Insurance Company & United Healthcare of Arkansas, Inc.,”* AID Order No. 2007-077; (2) *“In The Matter Of A Limited Scope Market Conduct Examination Of Arkansas Blue Cross & Blue Shield,”* AID Order No. 2007-078; and (3) *“In The Matter Of A Limited Scope Market Conduct Examination Of QCA Health Plan, Inc.,”* AID Order No. 2007-079. In the Adoption Orders, the Commissioner accepted and rejected various findings and conclusions in the Reports.

In each of the Adoption Orders, the Commissioner made the following series of common rulings applying to each Health Insurer: (1) that, for purposes of the “Any Willing Provider” law, particularly Ark. Code Ann. §23-99-204(a)(1)(B)(ii), the term “reimbursement” is interpreted to mean what is traditionally understood as “reimbursement” in the insurance industry, which is payment made to an insured or beneficiary to repay money the insured or beneficiary has expended for services received from a medical service provider, as distinguished from payments made by an insurer directly to a medical service provider pursuant to the insurance policy or health maintenance organization contract; (2) that, the Petitioner was paid less for the sampled

services compared to two (2) other member hospitals, however, each Health Insurer did not impose upon the Petitioner a "monetary penalty" under Ark. Code Ann. §23-99-204 because there was no evidence that beneficiary choice or patient choice to access the Petitioner was affected; (3) that, under Ark. Code Ann. §23-99-204(b), a health insurer may take into consideration the unique service and size characteristics of a hospital in its negotiation of individual provider payment rates because these directly affect the costs a health plan absorbs; and (4) a health insurer may, under Ark. Code Ann. §23-99-203(d)(11) and Ark. Code Ann. §23-99-802(4)(K), categorize hospitals differently due to size, location, scope of services and other distinguishing or unique factors in order to control costs, regulate utilization, or maintain quality as contemplated by Ark. Code Ann. §23-99-204(b) and Ark. Code Ann. §23-99-206.

In the Adoption Orders, the Commissioner made no findings or conclusions with respect to whether the Petitioner's payment differences violated §23-99-204(a)(3).

On January 30, 2008, the Petitioner requested an administrative hearing related to the Adoption Orders under Ark. Code Ann. §§23-61-303, 23-61-305 and 23-61-306. In its Petition for a hearing (hereafter, the "Hearing Request"), the Petitioner requested: (1) to take evidence on whether the monetary disadvantages imposed on Petitioner by virtue of the payment differences referenced in the Reports would affect a patient's choice under Ark. Code Ann. §23-99-204(a)(1)(A); (2) to present evidence on the amount or degree of negotiation that ABCBS offered its member hospitals as referenced in the Reports; (3) to give the Commissioner an opportunity to amend or supplement the Adoption Orders to demonstrate a violation of the "Any Willing Provider" law and whether such a violation has occurred or will likely occur in the future based on the

payment rates disclosed; and (4) to solidify the evidence with respect to whether the payments made by the three (3) insurers were determined because of quality or cost reasons or were solely related to the different size and scope of services provided by member hospitals. In addition, the Petitioner requested under Ark. Code Ann. §23-61-305(b) a reasonable opportunity to inspect documents and/or statements of witnesses provided in the Reports and requested the opportunity to issue subpoenas to compel the attendance of witnesses and the production of additional evidence. The Petitioner thereafter supplemented its Hearing Request on whether the insurance companies had violated Ark. Code Ann. §23-99-204(a)(1) and (a)(3), as more fully described in the hearing requests and supplements thereto.

On February 6, 2008, the Department granted Petitioner's Hearing Request under Ark. Code Ann. §23-61-305(b) setting the initial hearing date for February 25, 2008, at the Department. Due to scheduling conflicts, the hearing date was subsequently rescheduled to begin on April 14, 2008. From February 6, 2008, until the date of the final hearing on April 14, 2008, the Commissioner held four (4) preliminary hearings to consider intervention requests, discovery, and subpoena requests for information related to the Reports and Adoption Orders, as well as considered various Petitions for Declaratory Orders made by various parties. Under Ark. Code Ann. §23-61-305(c), the Commissioner permitted the following parties to intervene in the Petitioner's Hearing (hereafter, the "ASH Proceeding"): (1) Ouachita Regional Diagnostic & Surgery Center of Hot Springs, Inc. d/b/a HealthPark Hospital ("HealthPark"); (2) The Surgical Hospital of Jonesboro, LLC; (3) the Sisters of Mercy Health System; and (4) the Arkansas Hospital Association ("AHA").

Following a March 10, 2008, preliminary hearing at the Department, on March 21, 2008, over the objections of the Petitioner and Petitioner Intervenors, the Commissioner issued a Declaratory Order in response to a Petition for a Declaratory Order filed by the Health Insurers, which was joined in by intervenors AHA and the Sisters of Mercy Health System. The Declaratory Order repeated the Commissioner's common conclusions of law as announced in her Adoption Orders.

Throughout the preliminary hearings and final hearing, the Commissioner, over the objections of the Petitioner and Petitioner Intervenors, held that the payment information acquired from the Survey as well as information related to any hospital payment methodologies used by the Health Insurers to calculate payment amounts to hospitals were confidential information not subject to discovery or subpoena under Ark. Code Ann. § 23-61-207, and were confidential, trade secret information which would, if disclosed, provide information advantageous to a competitor. However, during the course of the final hearing, the Commissioner did permit the Petitioner and various Intervenors to examine representatives of the Health Insurers, *in-camera*, subject to certain restrictions, to submit evidence into the administrative record of general methodologies or procedures, factors, or bases, if any, used by a Health Insurer in calculating how the payments were determined.

From April 14, 2008, to April 17, 2008, the final hearing was held at the Department in which the Commissioner received into the administrative record documents and testimony from the parties. Testifying for the Petitioner were Lyndell H. Weaks, Chief Executive Officer of the Petitioner; Mike Brown, Chief Operating Officer of ABCBS; Michael Stock, President and CEO of QCA; Lawrence A. Nall, Vice

President of Network Management for United in Arkansas, Tennessee, and Virginia; Paul Burnett, Senior Network Account Manager for United; and Dr. Leo Berkenbile, M.D., an emergency room physician at Verdugo Hills Hospital in California. Testifying for the Petitioner Intervenors were Nate Miller, Chief Executive Officer of the Surgical Hospital of Jonesboro and Jason Spring, Chief Executive Officer of HealthPark. Testifying for the Health Insurers were Austin Gaines, Executive Director of Managed Care for Sisters of Mercy Health Systems; Michael Keck, Director of Medical Staff Development for St. Vincent Hospital; Paul Cunningham, Senior Vice President, Arkansas Hospital Association; Paul Burnett, Senior Network Account Manager for United; Eric Moxley, Director of Network Operations for United; and Dr. Joe Thompson, the Surgeon General of Arkansas and Associate Professor in the Department of Pediatrics at the University of Arkansas for Medical Science.

The Commissioner directed, upon stipulation by the parties to the hearing, that following April 17, 2008, the record to be left open until Monday, August 25, 2008, to allow for preparation and review of the transcript and submission of any proposed findings of fact and conclusions of law from the participants.

Given the similarity of the issues, law and facts, in each of the three (3) Adoption Orders, and, given that the final hearing involved one (1) combined hearing involving all of the Health Insurers, to simplify matters, the Commissioner hereby issues one Order, rather than three (3) separate Orders.

FINDINGS OF FACT

1. The Commissioner has adopted findings of fact under seal from the *in-camera* portions of this proceeding as a separate attachment to this Order.

2. In challenging the Adoption Orders, as the parties seeking relief to change or modify the Orders, the Petitioner and Petitioner Intervenors should have the burden of proof to change, modify, or nullify the Adoption Orders under Ark. Code Ann. § 23-61-305.

3. Although the Commissioner issued the Declaratory Order on March 21, 2008, intending to limit the scope and nature of the final hearing to findings and conclusions of law not already decided in the Declaratory Order, the Commissioner, in her discretion, did permit, hear, and receive administrative evidence, occasionally, which was not ruled confidential, and heard legal arguments again that may have related to whether the determinations in the Declaratory Order were met.

4. The Petitioner and Petitioner Intervenors are "Health care providers" as defined by Ark. Code Ann. §23-99-203(d) and Ark. Code Ann. §23-99-802(4).

5. The Health Insurers are "Health care insurers," as defined by Ark. Code Ann. 23-99-203(f) and Ark. Code Ann. §23-99-802(5).

6. The Health Insurers provide "health benefit plans" as defined by Code Ann. §23-99-203(c) and Ark. Code Ann. §23-99-802(3). The Petitioner and Petitioner Intervenors are participants in such plans.

7. The Commissioner re-adopts the findings in *"In The Matter Of A Limited Scope Market Conduct Examination Of Arkansas Blue Cross and Blue Shield, a Mutual*

Insurance Company," and AID Order No. 2007-078 related to the general factors which ABCBS states it considers in calculating its payment amounts to Petitioner and its in-network member hospitals.

8. According to evidence entered at the Hearing, ABCBS paid Petitioner less for the surveyed procedures than it paid Baptist Hospital and St. Vincent.

9. ABCBS did not specifically quantify in its surveyed payment calculations to Petitioner a list of the hospital's cost or quality factors which impact payment amounts per medical procedure.

10. ABCBS did not have a straight-line mathematical formula which connected specific cost and quality factors of Petitioner in determining the base rate used with Petitioner per surveyed procedure. ABCBS did not pay Petitioner less for the surveyed procedures because of specific, numerically weighted quality, cost, or efficiency reasons of Petitioner, per surveyed procedure.

11. In its calculation of base rates of member hospitals, ABCBS considers the amount of indigent care, emergency care, mix of services, and scope of services provided by its member hospitals. However, such factors are not numerically assigned or quantifiably weighted in such a way as to review the extent to which one or more of these factors specifically impacts or connects to its payment to a hospital for a particular medical procedure, on the basis of cost and quality measures.

12. ABCBS did not pay Petitioner less for a surveyed procedure than another hospital because the Petitioner failed to meet a specific cost or quality measure of ABCBS connected to the Petitioner's performance of that particular procedure.

13. The quality of services offered by Petitioner for the surveyed procedures is at least equivalent to those provided by Baptist Hospital or St. Vincent Hospital.

14. The Commissioner re-adopts the findings in *"In The Matter Of A Limited Scope Market Conduct Examination Of QCA Health Plan, Inc.,"* and AID Order No. 2007-079 related to the general factors which QCA states it considers in calculating its payment amounts to Petitioner and its in-network member hospitals. Under QCA's stated approach, a hospital's provider payment amount for a specific procedure is calculated by multiplying an assigned conversion factor of the hospital (base rate) times a Medicare case weight as a starting point. The ultimate amount of payment might also be affected by "outlier" and "inlier" provisions. The determination of the numerically assigned amount of the conversion factor, assigned to the hospital by QCA, is derived at by considering the hospital's geographical market factors, size, scope of services, cost, quality of care and overall ability to service the health plans offered by QCA.

15. According to evidence entered at the Hearing, QCA paid Petitioner less for the surveyed procedures than it paid Baptist Hospital and St. Vincent Hospital.

16. QCA did not specifically quantify in its surveyed payment calculations to Petitioner a list of the hospital's cost or quality factors which impact payment amounts per medical procedure.

17. QCA did not have a straight-line mathematical formula which connected specific cost and quality factors of Petitioner in determining the conversion factor used with Petitioner per surveyed procedure. QCA did not pay Petitioner less for the surveyed procedures because of specific, numerically weighted quality, cost, or efficiency reasons of Petitioner, per surveyed procedure.

18. In its calculation of the conversion factor for Petitioner, the factors of the hospital's geographical market, size, scope of services, cost, quality of care, and overall ability to service the health plans offered by QCA are not numerically assigned or quantifiably weighted in a specific way as to review the extent to which one or more of these factors specifically impacts or connects to its payment to a hospital for a particular medical procedure, on the basis of cost and quality measures.

19. QCA did not pay Petitioner less for a surveyed procedure than another surveyed hospital because the Petitioner failed to meet a specific cost or quality measure of QCA connected to the Petitioner's performance of that particular procedure.

20. The Commissioner re-adopts the findings in *"In The Matter Of A Limited Scope Market Conduct Examination Of United Healthcare Insurance Company & United Healthcare of Arkansas, Inc.,"* AID Order No. 2007-077; related to the factors which United states it considers in calculating its payment amounts to Petitioner and its in-network member hospitals. Under United's stated approach, a hospital's provider payment amount for a specific procedure is calculated by multiplying an assigned base rate times a Medicare case weight. The ultimate amount of payment may be affected by carve-outs or any additional payments that may be triggered by an excessive length of stay. The determination of the numerically assigned amount of the base rate, assigned to the hospital by United, is derived at by considering the hospital's size, scope of services, cost, quality of care and overall ability to service its health plans. United contends that, in establishing the base rates, it considers CMS's determination of base weight, charity care, patient populations, and severity and scope of services offered.

21. According to evidence entered at the Hearing, United paid Petitioner less for the surveyed procedures than it paid Baptist Hospital and St. Vincent.

22. United did not specifically quantify in its surveyed payment calculations to Petitioner a list of the hospital's cost or quality factors which impact payment amounts per medical procedure.

23. United did not have a straight-line mathematical formula which connected specific cost and quality factors of Petitioner in determining the conversion factor used with Petitioner per surveyed procedure. United did not pay Petitioner less for the surveyed procedures because of specific, numerically weighted quality, cost, or efficiency reasons of Petitioner, per surveyed procedure.

24. In its calculation of the base rate for Petitioner, the factors of geographical size, scope of services, cost, quality of care, and overall ability to service the health plans offered by United are not numerically assigned or quantifiably weighted in a specific way as to review the extent to which one or more of these factors specifically impacts or connects to its payment to a hospital for a particular medical procedure, on the basis of cost and quality measures.

25. United did not pay Petitioner less for a surveyed procedure than another surveyed hospital because the Petitioner failed to meet a specific cost or quality measure of United connected to the Petitioner's performance of that particular procedure.

26. The Commissioner finds, for each of the Health Insurers, that the "base rate" amounts assigned to the Petitioner were lower than those assigned to St. Vincent and Baptist Hospital, and that this "base rate" difference, when multiplied to the procedure's Medicare defined "case weight," resulted in lower payments to the Petitioner

per each sampled procedure. The Commissioner finds that the higher the "base rate" which is assigned to a hospital, generally, the higher the ultimate payment for the procedure to the hospital, although other factors may affect the ultimate payment amount to the hospital such as a patient's length of stay, the severity of the case, and other contractual carve outs or provisions. The Commissioner finds, from testimony of the hospital witnesses for Petitioner and Petitioner Intervenors, that the amount of payment received from each Health Insurer affects its decisions to continue to participate in the health plans with each Health Insurer.

27. The Commissioner finds that, for each of the Health Insurers, the factors establishing the "base rate" by each Health Insurer, such as size and the total scope of services of a hospital, were not quantifiably connected in a numerical way, such that a particular hospital service was weighted in the payment calculation, as a cost or quality measure, in a particular procedure. The Commissioner finds that for each Health Insurer, the factors or criteria which determine the Health Insurer's assignment of a specific base rate of Petitioner and Petitioner Intervenors were not listed in writing by the Health Insurer nor supplied to Petitioner or Petitioner Intervenors at the inception of the provider network contracts; however the total scope of the hospital services of Petitioner and Petitioner Intervenors were overall, general quality of care and cost concerns of each Health Insurer in establishing its base rates.

28. According to Barron's *Dictionary of Insurance Terms* (3rd Edition), the phrase, "reimbursed benefits," means "payments by the insurance company to the insured for the actual expenses incurred by the insured, such as medical expenses." According to Barron's *Dictionary of Insurance Terms* (3rd Edition), the phrase, "reimbursement of

insured," means "payment of benefits by an insurance policy to a policyowner (usually the insured) if a loss occurs."

29. Each Health Insurer has a set of rate-setting considerations that it applies when negotiating with each hospital. In negotiating contract payments with hospitals, the insurers rely upon factors such as each hospital's scope of services and the outcomes of procedures, the hospital's cost structure, the lengths of patient stays, utilization rates, and the availability of hospital services within the geographic area in which the hospital operates. Insurers consider these factors in light of the premiums they charge consumers in the market place for health insurance policies. The scope of services offered, as well as quality and cost considerations, are substantial factors in the negotiations.

30. No two hospitals are identical in the services they offer to their communities or the business models they choose to employ. As such, the rates paid by insurance carriers to hospitals are not identical. In addition, variances in rates are sometimes due to the request of the hospital system itself.

31. Various bases exist for differentiating payments among hospitals for the same services, including the costs of providing patient services, occupational mix of hospital employees, geographic location, type and breadth of services provided, case mix, payer mix, patient mix (including the number of uninsured and low income patients served), degree of utilization of healthcare and information technology, size, and quality of care programs and practices.

32. Government payers do not pay all hospitals the same rate for similar services. The federal Medicare system recognizes the distinctions between individual hospitals, and pays each hospital differently based on a DRG payment methodology.

33. The Arkansas Department of Health recognizes some distinctions between hospitals by issuing hospital licenses with various designations, as outlined in its Rules and Regulations for the Licensure of Hospitals and Related Institutions.

34. Neither Petitioner nor Petitioner Intervenors are being prohibited from an opportunity to participate in any of the Health Insurers' health plans. Each Health Insurer has a network contract with Petitioner and with Intervenor Health Park. QCA and ABCBS have a network contract with Intervenor Surgical Hospital of Jonesboro.

35. Although United does not have a contract with Intervenor Surgical Hospital Of Jonesboro, United attempted to reach such an agreement, until Intervenor Surgical Hospital of Jonesboro indicated that it had decided to suspend negotiation due to market conditions. United remains willing to negotiate with Intervenor Surgical Hospital of Jonesboro.

36. Petitioner is a hospital whose primary focus has been on orthopedic surgery, spine surgery, cosmetic surgery, and pain management. Petitioner has recently added breast oncology services. When Petitioner opened, it had sixteen (16) beds and five (5) operating rooms. Petitioner's net income was $1,500,000 in 2006, and $200,000 in 2007. In April 2006, Petitioner began an expansion to increase its capacity to forty-one (41) beds and eleven (11) operating rooms. The cost of Petitioner's expansion was approximately $13,000,000. The physician-owners of Petitioner perform 65% to 70% of the overall procedures conducted at the Petitioner. Currently, the Petitioner does not have obstetrical capabilities, cardiac services capabilities, an intensive care unit, pediatric capabilities, or an emergency room staffed by a physician 24 hours per day, seven days per week. Because Petitioner does not offer a full scope of services as does a larger

hospital, the Petitioner may have to transfer patients by ambulance to an acute-care hospital for treatment of emergency medical conditions it cannot service.

37. Because the Health Insurers do not issue health plans or health policies tailored just to cover a limited number of medical procedures, but must cover all reasonable medical care of the beneficiary, the Health Insurers have cost and quality concerns for hospitals which do not provide a full scope of services in one place, due to emergency care issues and transfer issues.

38. Before the Commissioner can issue a license to a health maintenance organization ("HMO") to operate in Arkansas, the Director of the Arkansas Department of Health must determine whether the applicant for an HMO license has demonstrated the "ability to assure that the health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability and accessibility and continuity of service." (Ark. Code Ann. § 23-76-108(a)(2)(A)). Arkansas Department of Health Rules and Regulations for HMOs require that HMOs provide availability and accessibility of a broad range of services. In addition, the nature of the healthcare marketplace requires that health insurers and HMOs provide a broad range of medical services to their subscribers.

39. Hospital services that are typically unprofitable, and therefore must be supported by other sources of revenue (such as the revenue from the hospital's profitable service lines), include emergency services, obstetrics, intensive care, and teaching services.

40. Community hospitals provide broad access to care through their emergency rooms. For example, approximately 21% of emergency room visits are

admitted to St. Vincent. Of those, approximately 12.5% of admissions are comprised of indigent patients.

41. Hospitals with a full scope of services have a concern that if hospitals must be paid the same amount for similar procedures, then the question will arise as to whether the rate paid to all hospitals should be raised to the highest rate currently paid to any hospital for that procedure, lowered to the lowest rate currently paid, or set somewhere in between. Full-scope hospitals are concerned that should the common rate be set to the lowest rate currently paid to any hospital for a particular procedure, the revenue generated by more profitable services would be insufficient to cover the financial shortfall created by unprofitable services. This shortfall would force community hospitals to discontinue costly but necessary services, decreasing quality of care and access to care.

42. Petitioner and Petitioner Intervenors have stated that they are not arguing to be paid the same identical amount for a similarly performed procedure as another hospital, but desire that the Health Insurers apply a common, objective methodology in its payment criteria.

CONCLUSIONS OF LAW

1. The Arkansas Insurance Code requires the Commissioner to enforce the State's "Any Willing Provider" law using the powers granted to the Commissioner in the Arkansas Insurance Code. Ark. Code Ann. § 23-99-803(1).

2. The Arkansas Insurance Code provides that in enforcing the state's laws, the Commissioner must give primary consideration to protection of the consumer. Ark. Code Ann. §23-61-101(c)(1)(B).

3. The Arkansas Insurance Code provides that the Insurance Commissioner shall have the powers expressly conferred or reasonably implied from the provisions of the Arkansas Insurance Code. Ark. Code Ann. § 23-61-103(b).

4. The stated legislative purpose of the "Any Willing Provider" law is to give patients the opportunity to see the healthcare provider of their choice by giving healthcare providers the opportunity to participate in health benefit plans. Ark. Code Ann. § 23-99-202.

5. As the Commissioner has previously ruled in this proceeding, in reviewing whether a "monetary penalty" is imposed pursuant to Ark. Code Ann. § 23-99-204(a)(1)(B)(ii), the Commissioner notes a specific reference in Ark. Code Ann. § 23-99-204(a)(1)(B)(ii) to the term "reimbursement" in the phrase "a reduction in reimbursement for services." The Commissioner continues to interpret the term "reimbursement" to mean what is traditionally understood by the term "reimbursement," in the insurance industry, as payment made to an insured or beneficiary to repay money the insured or beneficiary has expended for services received from a medical service provider, as distinguished from payments made by an insurer directly to a medical service provider pursuant to the insurance policy or health maintenance organization contract.

6. Nonetheless, even if the legislative intent was to apply Ark. Code Ann. § 23-99-204(a)(1)(B)(ii) to payments made to a medical service provider in a network provider contract, as reviewed in this proceeding, Ark. Code Ann. §23-99-206 clearly

states that nothing in this subchapter ["Any Willing Provider" law] shall constitute a violation on the basis of actions taken by the health benefit plan to maintain quality, enforce utilization regulations, and to control costs. Also, Ark. Code Ann. §23-99-204(b), states that nothing in this subchapter ["Any Willing Provider" law] shall prevent a health benefit plan from instituting measures designed to maintain quality and to control costs, including, but not limited to, the utilization of a gatekeeper system, as long as such measures are imposed equally on all providers in the same class.

7. Ark. Code Ann. §23-99-204(a)(3) states that a health care insurer shall not prohibit or limit a health care provider that is qualified under Ark. Code Ann. §23-99-203(d) and is willing to accept the health benefit plan's operating terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards, from the opportunity to participate in the plan. Unlike Ark. Code Ann. § 23-99-204(a)(1), this subdivision is not restricted to reviewing whether a health insurer's action affects "reimbursement" in a "health benefit plan" but would apply to network provider contracts. Nonetheless, as it applies to reviewing whether a medical provider is "prohibited" or "limited" from participation in the plan from provider payment differences in the network provider contracts, it is important to once again recognize Ark. Code Ann. §23-99-206 and Ark. Code Ann. §23-99-204(b) which permit health insurers to take actions to maintain quality and to control costs.

8. The Commissioner determines that, in this case, although the specific factors or circumstances affecting a Health Insurer's base rate assignment for the Petitioner differed, the primary factors appeared to be what other similarly sized hospitals received for base rate amounts, as well as the total scope of health care services provided

by Petitioner. The Commissioner holds that a health insurer may vary payment between in-network member hospitals based on the scope of total health care services provided by a hospital, because the total scope of services provided by a hospital are cost and quality concerns of the health insurer, as well as are factors such as case mix, payer mix, patient mix (including the number of uninsured and low income patients served), degree of utilization of healthcare and information technology, size, and quality of care programs and practices. Even if the quality of care of any particular procedure is equal to that same one performed at hospitals with a larger scope of services, the Commissioner determines that health insurers may consider a hospital's overall capacity to provide overall services in terms of "quality" as hereafter defined in paragraph twelve (12) of this Order. Because a hospital's overall ability to provide a large range of immediate services is an important factor for health insurers to consider to meet the requirements of their health benefit plans, the Commissioner determines that this factor is equally considered and imposed on all hospitals in the same class desiring network participation with that health insurer.

9. The Commissioner interprets that, for purposes of reviewing whether a violation of the "Any Willing Provider" law exists under either Ark. Code Ann. § 23-99-204(a)(1)(B)(ii) or Ark. Code Ann. §23-99-204(a)(3), because of payment differences between in-network hospitals over similarly performed procedures, health insurers do not violate such provisions under Code Ann. §23-99-204(b) or Ark. Code Ann. §23-99-206 if the payment differences derive from a health insurer's action to maintain quality and to control costs.

10. The Commissioner finds that under Ark. Code Ann. §23-99-206 or Ark. Code Ann. §23-99-204(b) a health insurer may take into consideration the unique service

and size characteristics of a hospital in its negotiation of individual provider payment rates because these directly affect the costs a health plan absorbs. The Commissioner finds that the "Any Willing Provider" law does not require identical payment to hospitals for similarly performed services. A health insurer may vary payment for similarly performed services because of cost or quality reasons related to the different size and scope of services provided by other member hospitals under Ark. Code Ann. §23-99-204(b) and Ark. Code Ann. §23-99-206.

11. "Costs," as used in Ark. Code Ann. §§ 23-99-204(b) and 23-99-206, are not limited to the costs incurred by a hospital in delivering its services to patients, but also include the costs to insurers in securing the availability of a broad range of health care services to their customers and to consumers in securing access to medical care and health insurance coverage, as well as the overall costs of the system of healthcare in Arkansas.

12. "Quality," as used in Ark. Code Ann. §§ 23-99-204(b) and 23-99-206, is not limited to the outcome or results of any particular service or procedure offered by any particular hospital, but includes the scope and breadth of healthcare services made available to consumers by a hospital, the scope of services offered throughout the State, as well as the overall ability of the healthcare delivery system to meet the needs of consumers.

13. The Commissioner interprets Ark. Code Ann. §23-99-203 and Ark. Code Ann. §23-99-802(4)(K) to not require "hospitals" to be classified as a single, indivisible class and that, as it relates to actions undertaken by a health insurer under Ark. Code

Ann. §§ 23-99-204(b) and 23-99-206, health insurers may consider each hospital's own unique service characteristics and scope of services.

THEREFORE:

The Commissioner finds that although the Petitioner was paid less than other in-network members for similarly performed procedures, the Health Insurers did not violate the "Any Willing Provider" law in that the Health Insurers took actions to maintain quality and to control costs within the meaning of Ark. Code Ann. §§ 23-99-204(b) and 23-99-206.

IT IS SO ORDERED THIS 15th DAY OF SEPTEMBER, 2008.

Julie Benafield Bowman

Julie Benafield Bowman
Arkansas Insurance Commissioner