

# AGENDA

## Joint Performance Review Committee

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Thursday, October 30, 2008

01:30 PM

Room 151, State Capitol  
Little Rock, Arkansas

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Sen. Terry Smith, Chair  
Sen. John Paul Capps, Vice Chair  
Sen. Jim Hill  
Sen. Jim Argue  
Sen. Dave Bisbee  
Sen. Jack Critcher  
Sen. Ruth Whitaker  
Sen. Sharon Trusty  
Sen. Bobby Glover  
Sen. Bill Pritchard

Rep. David Evans, Chair  
Rep. Lindsley Smith, Vice Chair  
Rep. Linda Chesterfield  
Rep. Benny Petrus  
Rep. Sid Rosenbaum  
Rep. Horace Hardwick  
Rep. Sandra Prater  
Rep. Betty Pickett  
Rep. James Norton  
Rep. Tommy Dickinson

Rep. Michael Lamoureux  
Rep. Bill Abernathy  
Rep. Roy Ragland  
Rep. Rick Green  
Rep. Stephanie Flowers  
Rep. Mike Burris  
Rep. Bill Sample  
Rep. Ray Kidd  
Rep. Fred Allen  
Rep. Lance Reynolds

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A. Call to Order.

B. Approval of Minutes—October 1, 2, & 3, 2008 **[Exhibit B, B-1, B-2]**

C. Discussion of the ruling by the Arkansas Insurance Commissioner, Ms. Julie Benafield Bowman, concerning the Patient Protection Act of 1995 (Act 505), also known as the “Any Willing Provider” law (§23-99-201 et.seq.). **[Exhibit C, Ca]**

1. Comments by Ms. Julie Benafield Bowman, State Insurance Commissioner, and Mr. Booth Rand, Chief Counsel, Arkansas Insurance Department **[Exhibit C-1, C-1a, C-1b]**
2. Comments by Mr. David Wroten, Executive Vice President, Arkansas Medical Society
3. Comments by physician and former state legislator, Dr. Scott Ferguson
4. Comments by Mr. Sam Perroni, attorney, The Perroni Firm
5. Reply/Comments Interested Parties

D. Adjournment

**Notice: Silence your cell phones. Keep your personal conversations to a minimum. Observe restrictions designating areas as "Members and Staff Only"**

***DRAFT*****JOINT PERFORMANCE REVIEW COMMITTEE****MINUTES****OCTOBER 1, 2008**

The Joint Performance Review Committee met, along with authorized members of the following committees: House Interim Committee on Aging, Children & Youth, Senate Interim Insurance & Commerce Committee, House and Senate Interim Education Committees, House and Senate Interim City, County & Local Affairs Committees, House and Senate Interim State Agencies & Governmental Affairs Committees, House Interim Public Health Committee, House and Senate Interim Revenue & Taxation Committees, and House and Senate Interim Agriculture, Forestry & Economic Development Committees. The meeting was held Wednesday, October 1, 2008 at 3:30 p.m. in the Conference Center, Lindsey's Resort, Heber Springs. Senator Terry Smith, Co-Chair, presided.

JPR members present were Senators Terry Smith, Co-Chair, and Ruth Whitaker, and Representatives Tommy Dickinson, David Evans, Co-Chair, Lance Reynolds, and Bill Sample.

Members of committees authorized to attend were: Senators Jimmy Jeffress and Randy Laverty, and Representatives Joan Cash, Buddy Lovell, Mike Patterson, Johnnie Roebuck, and Rick Saunders.

Chairman Terry Smith opened the meeting. The minutes of the September 24 meeting of the Joint Performance Review Committee were approved by acclamation.

Chairman Smith noted the meeting is being held in the district of Representative Lance Reynolds. Representative Reynolds expressed his thanks to those in attendance.

Chairman Smith recognized Joe David Rice, Director of Tourism, Arkansas Department of Parks and Tourism (ADPT). Mr. Rice talked briefly about the department's cooperative work with other agencies, including the National Forest Service, Arkansas Economic Development Commission, Department of Arkansas Heritage, the Arkansas Game and Fish Commission, and the Arkansas State Highway Department. He also noted ADPT has partnered with local television stations in promoting the state as another example in which the department has maximized taxpayer dollars.

Mr. Rice spoke of the recent economic down-turn and its effect on the state's tourism industry. He compared travel and tourism statistics with those of contiguous states, which revealed Arkansas has fared better than some of its neighbors in spite of its smaller budget.

Mr. Rice told the committee that ADPT contracted with Economics Research Associates (ERA) and Longwoods International to objectively assess the state's tourism industry and recommend a strategy to strengthen the state's tourism economy. Mr. Shelby Woods with Cranford, Johnson, Robinson, Woods (CJRW) was asked to comment on the research and strategy recommendations of ERA/Longwoods. Mr. Woods showed a power point presentation highlighting the ERA/Longwoods study. Karen Mullikin with CJRW followed with a video of the proposed media campaign for the coming year, which implements strategy from the ERA/Longwoods research recommendations.

Greg Butts, Director of Arkansas State Parks, was recognized. Mr. Butts stated that this year marks the 75th Anniversary of the Arkansas State Parks system. He spoke of the economics of visitation

## **EXHIBIT B**

and spending in Arkansas related to visits to the state parks. Mr. Butts pointed out that the state parks website, in addition to providing information, has become a tool for sharing visitor experiences. He also told of the public's interest in geocaches and the revenue generated because of this high-tech activity. Mr. Butts spoke of the rich history of the Arkansas State Parks system, followed by a video commemorating the 75th Anniversary of Arkansas State Parks. He then asked that ADPT staff in attendance introduce themselves.

Chairman Smith acknowledged Parks and Tourism staff for their good work and for the informative presentation.

Meeting was adjourned at 4:45 p.m.

***DRAFT***

**JOINT PERFORMANCE REVIEW COMMITTEE  
MINUTES  
OCTOBER 2, 2008**

The Joint Performance Review Committee met, along with authorized members of the following committees: House Interim Committee on Aging, Children & Youth, Senate Interim Insurance & Commerce Committee, House and Senate Interim Education Committees, House and Senate Interim City, County & Local Affairs Committees, House and Senate Interim State Agencies & Governmental Affairs Committees, House Interim Public Health Committee, House and Senate Interim Revenue & Taxation Committees, and House and Senate Interim Agriculture, Forestry & Economic Development Committees. The meeting was held Thursday, October 2, 2008 at 8:30 a.m. at the Green Dental Laboratories, Inc., Heber Springs. Senator Terry Smith, Co-Chair, presided.

JPR members present were Senators Terry Smith, Co-Chair, Representatives Tommy Dickinson, Lance Reynolds, Bill Sample, David Evans, Co-Chair, Lance Reynolds, and Bill Sample.

Members of committees authorized to attend were: Senator Randy Laverty, and Representatives Stan Berry, Joan Cash, Eddie Cooper, Larry Cowling, Monty Davenport, Curren Everett, Johnny Hoyt, Buddy Lovell, Daryl Pace, Mike Patterson, Johnnie Roebuck, Rick Saunders and Jon Woods.

Chairman Smith opened the meeting.

Mr. Neil Ingram, Marketing Director of Green Dental Laboratories welcomed the group. He stated that the company, one of the top 10 dental labs in the U.S., has 200 employees and a \$21.5 million payroll. The lab specializes in dental lab management practices and services. Mr. Ingram stated their biggest challenge, with the rapid changes in dental technology today, is training. On-site employee training, for the specialized, precision work provided by the lab, takes anywhere from three months to one year. The business, which began in October, 1980, in the back of a dental office, has grown to \$21 million in sales annually, with accounts in all 50 states. Following the overview of the business, tours of the lab were conducted.

After touring the facility, the group boarded two buses for field trips to natural gas sites to include an active shale gas drilling site south of Heber Springs, a compressor station near Quitman, and the Sneed Frac Pond near Quitman.

The group returned to Lindsey's for lunch and afternoon activities.

***DRAFT***

**JOINT PERFORMANCE REVIEW COMMITTEE  
MINUTES  
OCTOBER 3, 2008**

The Joint Performance Review Committee met, along with authorized members of the following committees: House Interim Committee on Aging, Children & Youth, Senate Interim Insurance & Commerce Committee, House and Senate Interim Education Committees, House and Senate Interim City, County & Local Affairs Committees, House and Senate Interim State Agencies & Governmental Affairs Committees, House Interim Public Health Committee, House and Senate Interim Revenue & Taxation Committees, and House and Senate Interim Agriculture, Forestry & Economic Development Committees. The meeting was held Friday, October 3, 2008 at 8:30 a.m. at the Arkansas State University - Heber Springs Campus. Senator Terry Smith, Co-Chair, presided.

JPR members present were Senators Terry Smith, Co-Chair, and Representatives Tommy Dickinson and Lance Reynolds.

Members of those committees authorized to attend were: Senator Randy Lavery and Representatives Eddie Cooper, Monty Davenport, Curren Everett, Johnny Hoyt, Buddy Lovell, Rick Saunders, and Jon Woods.

Chairman Smith opened the meeting and commented on the beautiful campus and setting. He thanked ASU for providing breakfast and tours of the facility. Senator Smith introduced Dr. Diane Tiner, Vice Chancellor, ASU Heber Springs.

Dr. Tiner welcomed the group, and recognized Chancellor Dr. Eugene McKay and staff from ASU Beebe and Heber Springs. Dr. Tiner asked her Director of Advancement to provide an update on ASU Heber Springs. Following a brief power point presentation, it was stated that ASU-Heber Springs has grown from 82 students in 1998 to 731 students in 2007-08. It was noted that, with the rising cost in tuition, two year campuses are becoming more important than ever.

Chairman Smith recognized former state representative Danny Ferguson with Southwestern Energy Company. Mr. Ferguson gave an update on the Fayetteville Shale and Southwestern Energy Company. He pointed out that Southwestern Energy Company discovered the Fayetteville Shale as a viable natural gas source for the nation's domestic gas supply. Mr. Ferguson stated that the highly technical industry is still evolving. He stated, until a few years ago, the technology did not exist to extract natural gas out of shale. Southwestern Energy's drilling budget for 2008 is \$1.3 billion. The company has completed 619 wells to date, with most being horizontal wells. The Fayetteville Shale differs in thickness, but generally consists of an approximate 250' thickness of the dense rock formation of shale. Southwestern Energy production of natural gas, as of July 1 of this year, was one-half billion cubic feet of natural gas per day.

Mr. Ferguson stated that horizontal drilling has less surface disturbances than vertical drilling. Fewer wells are required per section with horizontal drilling to contact more of the shale. Southwestern Energy currently holds approximately 850,000 acres under lease.

## EXHIBIT B-2

Regarding infrastructure, Mr. Ferguson explained, the gathering lines go from the individual wells and feed the gathering collection pipes and eventually go to the main transmission lines to market. Using the drilling site toured yesterday as an example, gas comes out of the ground at around 40-50 pounds per square inch (not much more pressure than in vehicle tires). By the time the product goes to a major transmission line to be sold at market, it has to be compressed to as high as 1600 psi. That explains the need for the compression sites such as the one toured yesterday. Mr. Ferguson noted there have been announcements of two major transmission lines being built to take care of the Fayetteville Shale, a necessity to keep the wells active and to get the gas to market.

Mr. Ferguson said the U.S. is importing 2/3 of the oil needed. In contrast, the U.S. is producing over 80% of the natural gas needed, one of the cleanest burning fuels of all of the hydrocarbons. According to projections, the Fayetteville Shale could easily be producing 3-5% of our nation's domestic natural gas supply. Most of the natural gas that the U.S. imports comes from Canada. Mr. Ferguson stated Canada has put the U.S. on notice of the need to curtail exports due to increased need for natural gas in their country.

Regarding economic impact, Mr. Ferguson stated the University of Arkansas Center for Business & Economic Research recently completed an independent study on the Fayetteville Shale. According to the report, from 2008-2012, Fayetteville Shale is projected to have a \$17.8 billion economic impact on Arkansas, with \$1.8 billion generated in new state taxes and \$151 million in local taxes. Mr. Ferguson noted that the projections were based on the old severance tax rate. Therefore, the projected \$1.8 billion in new state taxes should be considerably higher because of the new severance tax rate.

Mr. Ferguson noted the number one challenge to the natural gas industry in Arkansas is the availability of a trained work force. Initially, drill site workers were brought in from other states. Now 80% of Southwestern Energy employees are Arkansans. Mr. Ferguson commended ASU for adding the training to their curriculum. It was stated that geology and engineering are fields in which there are tremendous job opportunities in Arkansas and other energy producing states in the oil and gas industries.

Mr. Ferguson ended his update by stating the challenges of the industry. One, being the workforce, was discussed earlier. Second, natural gas prices are a factor, because a significant reduction could slow down horizontal drilling. Third, regulation in protecting the environment (of which the state legislature is doing a good job) in concert with a pro business climate to develop these resources in a responsible way is important.

Mr. Ferguson stated, in answer to a follow-up question, that the state is probably looking at a 20-year drilling program.

The meeting was adjourned.

**Subchapter 2**  
**— Patient Protection Act of 1995**

- 23-99-201. Short title.
- 23-99-202. Legislative findings and intent.
- 23-99-203. Definitions.
- 23-99-204. Terms of health benefit plan.
- 23-99-205. Construction.
- 23-99-206. Violations.
- 23-99-207. Civil penalties.
- 23-99-208. Void provisions.
- 23-99-209. Applicability.

**A.C.R.C. Notes.** Acts 1995, No. 505, § 12, provided:

“In the event any portion of this act is found to be in violation of federal law or in conflict therewith, or held to be unconstitutional, that portion shall hereby be repealed and all other portions of this act shall remain in force.”

Acts 1995, No. 1193, § 9, provided:

“In the event any portion of this act is found to be in violation of federal law or in conflict therewith, or held to be unconstitutional, that portion shall hereby be repealed and all other portions of this act shall remain in force.”

**Publisher's Notes.** In 1997, this subchapter was held to be preempted by the federal Employment Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., and a permanent injunction barring the enforcement of this subchapter was granted. See *Prudential Ins. Co. of America v. National Park Medical Ctr.*, 964 F. Supp. 1285 (E.D. Ark. 1997), aff'd, 154 F.3d 812 (8th Cir. 1998). However, the permanent injunction was subsequently dissolved based upon a decision by the United States Supreme Court involving similar statutory law of another state. See *Prudential Ins. Co. of America v. National Park Medical Ctr., Inc.*, — F. Supp. 2nd, —, 2004 U.S. Dist. LEXIS 2906 (E.D. Ark. Feb. 12, 2004.) aff'd in part, rev'd in part, and remanded, 413 F.3d 897 (8th Cir. 2005).

**Cross References.** Enforcement of any willing provider laws, § 23-99-801 et seq.

**Research References**

**U. Ark. Little Rock L.J.**

Price, Pre-emption “Between the Poles:” ERISA’s Effect on State Common Law Actions Other than Benefit Claims. 19 U. Ark. Little Rock L.J. 541.

**23-99-201. Short title.**

This subchapter may be cited as the “Patient Protection Act of 1995”.

**History.** Acts 1995, No. 505, § 1.

## RESEARCH REFERENCES

### U. Ark. Little Rock L. Rev.

Note, Puncturing the Funnel — Saving the “Any Willing Provider” Statutes from ERISA Preemption, 27 U. Ark. Little Rock L. Rev. 407.

### Case Notes

Construction With Other Law.  
Federal Preemption.

### Construction With Other Law.

Patient Protection Act, § 23-99-201 et seq., was not repealed by the Freedom of Choice Among Health Benefit Plans Act of 1999, § 23-86-401 et seq. Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc., — F. Supp.2d —, 2004 U.S. Dist. LEXIS 2906 (E.D. Ark. Feb. 12, 2004), aff'd in part, rev'd in part, 413 F.3d 897 (8th Cir. 2005).

### Federal Preemption.

A permanent injunction barring health care providers who were seeking admittance into an insurer's exclusive provider networks pursuant to the Patient Protection Act was dissolved pursuant to Fed. R. Civ. P. 60(b)(5) after the U.S. Supreme Court held that a similar law in Kentucky was not preempted by ERISA, on the basis that the Supreme Court decision constituted an extraordinary circumstance. Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc., — F. Supp.2d —, 2004 U.S. Dist. LEXIS 2906 (E.D. Ark. Feb. 12, 2004), aff'd in part, rev'd in part, 413 F.3d 897 (8th Cir. 2005).

### 23-99-202. Legislative findings and intent.

The General Assembly finds that patients should be given the opportunity to see the health care provider of their choice. In order to assure the citizens of the State of Arkansas the right to choose the provider of their choice, it is the intent of the General Assembly to provide the opportunity of providers to participate in health benefit plans.

**History.** Acts 1995, No. 505, § 2.

### Case Notes

**Cited:** Prudential Ins. Co. of America v. National Park Medical Ctr., 964 F. Supp. 1285 (E.D. Ark. 1997).

### 23-99-203. Definitions.

(a) (1) “Copayment” means a type of cost sharing whereby insured or covered persons pay a specified predetermined amount per unit of service or percentage of health care costs with their health care insurer paying the remainder of the charge.

(2) The copayment is incurred at the time the service is rendered.

(3) The copayment may be a fixed or variable amount.

(b) “Gatekeeper system” means a system of administration used by any health benefit plan in which a primary care provider furnishes basic patient care and coordinates diagnostic testing, indicated treatment, and specialty referral for persons covered by the health benefit plan.

(c) “Health benefit plan” means any entity or program that provides reimbursement, including capitation, for health care services, except and excluding any entity or program that provides reimbursement and benefits pursuant to Arkansas Constitution, Amendment 26, Acts 1993, No. 796, or the Public Employee Workers' Compensation Act, § 21-5-601 et seq., and rules, regulations, and schedules adopted thereunder.

(d) “Health care provider” means those individuals or entities licensed by the State of Arkansas to provide health care services, limited to the following:

- (1) Advanced practice nurses;
- (2) Athletic trainers;
- (3) Audiologists;
- (4) Certified orthotists;
- (5) Chiropractors;
- (6) Community mental health centers or clinics;
- (7) Dentists;
- (8) Home health care;
- (9) Hospice care;
- (10) Hospital-based services;
- (11) Hospitals;
- (12) Licensed ambulatory surgery centers;
- (13) Licensed certified social workers;
- (14) Licensed dietitians;
- (15) Licensed professional counselors;
- (16) Licensed psychological examiners;
- (17) Long-term care facilities;

- (18) Occupational therapists;
- (19) Optometrists;
- (20) Pharmacists;
- (21) Physical therapists;
- (22) Physicians and surgeons (M.D. and D.O.);
- (23) Podiatrists;
- (24) Prosthetists;
- (25) Psychologists;
- (26) Respiratory therapists;
- (27) Rural health clinics; and
- (28) Speech pathologists.

(e) “Health care services” means services and products provided by a health care provider within the scope of the provider's license.

(f) “Health care insurer” means any entity, including, but not limited to:

- (1) Insurance companies;
- (2) Hospital and medical service corporations;
- (3) Health maintenance organizations;
- (4) Preferred provider organizations;
- (5) Physician hospital organizations;
- (6) Third party administrators; and
- (7) Prescription benefit management companies,

authorized to administer, offer, or provide health benefit plans.

**History.** Acts 1995, No. 505, § 3; 1995, No. 1193, § 1; 2005, No. 2238, § 1.

**Amendments.** The 2005 amendment inserted present (d)(2).

#### **Case Notes**

**Cited:** Prudential Ins. Co. of America v. National Park Medical Ctr., 964 F. Supp. 1285 (E.D. Ark. 1997).

**23-99-204. Terms of health benefit plan.**

(a) A health care insurer shall not, directly or indirectly:

(1) (A) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice among those health care providers who participate in the health benefit plan according to the terms offered.

(B) "Monetary advantage or penalty" includes:

(i) A higher copayment;

(ii) A reduction in reimbursement for services; or

(iii) Promotion of one (1) health care provider over another by these methods;

(2) Impose upon a beneficiary of health care services under a health benefit plan any copayment, fee, or condition that is not equally imposed upon all beneficiaries in the same benefit category, class, or copayment level under that health benefit plan when the beneficiary is receiving services from a participating health care provider pursuant to that health benefit plan; or

(3) Prohibit or limit a health care provider that is qualified under § 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 that plan.

(b) Nothing in this subchapter 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.

**History.** Acts 1995, No. 505, § 4; 1995, No. 1193, § 2.

**23-99-205. Construction.**

(a) Nothing in this subchapter shall be construed to require any health care insurer to cover any specific health care service.

(b) Provided, however, no condition or measure shall have the effect of excluding any type or class of provider qualified under § 23-99-204(a)(3) to provide that service.

**History.** Acts 1995, No. 505, § 5; 1995, No. 1193, § 3.

## Case Notes

In General.

### In General.

A permanent injunction barring health care providers who were seeking admittance into an insurer's exclusive provider networks pursuant to the Patient Protection Act was dissolved pursuant to Fed. R. Civ. P. 60(b)(5) after the U.S. Supreme Court held that a similar law in Kentucky was not preempted by ERISA, on the basis that the Supreme Court decision constituted an extraordinary circumstance. *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, — F. Supp.2d —, 2004 U.S. Dist. LEXIS 2906 (E.D. Ark. Feb. 12, 2004), *aff'd in part, rev'd in part*, 413 F.3d 897 (8th Cir. 2005).

### 23-99-206. Violations.

It is a violation of this subchapter for any health care insurer or other person or entity to provide any health benefit plan providing for health care services to residents of this state that does not conform to this subchapter, but nothing in this subchapter 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.

**History.** Acts 1995, No. 505, § 8.

### 23-99-207. Civil penalties.

To the extent permitted by ERISA, the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq., any provider adversely affected by a violation of this subchapter may sue in circuit court only for injunctive relief against the health care insurer, but not for damages. The prevailing party shall be allowed a reasonable attorney's fee and costs.

**History.** Acts 1995, No. 505, § 6; 2005, No. 960, § 1.

**Amendments.** The 2005 amendment rewrote this section.

## RESEARCH REFERENCES

### U. Ark. Little Rock L. Rev.

Survey of Legislation, 2005 Arkansas General Assembly, Insurance Law, 28 U. Ark. Little Rock L. Rev. 393.

## Case Notes

Suits for Damages.

### Suits for Damages.

Anti-Injunction Act, 28 U.S.C.S. § 2283, deprived the district court of jurisdiction over the suit filed by

two health insurance companies under the All Writs Act, 28 U.S.C.S. § 1651, which sought to enjoin several health care providers from prosecuting a state court suit against the companies. The relitigation exception to Anti-Injunction Act did not apply because the court had not previously entered a final judgment determining the providers' claims under the Arkansas Any Willing Provider statute or their claims for damages under the pre-2005 version of this section. *Ark. Blue Cross & Blue Shield v. St. Vincent Infirmary Med. Ctr.*, — F. Supp. 2d —, 2007 U.S. Dist. LEXIS 92101 (E.D. Ark. Dec. 5, 2007).

Neither the res judicata nor collateral estoppel doctrines applied to bar the claims asserted by several health providers against two health insurance companies under the Arkansas Any Willing Provider (AWP) statute or their claims for damages under the pre-2005 version of this section because: (1) although the providers had asserted their claims in a prior suit, the claims had been dismissed without prejudice pursuant to 28 U.S.C.S. § 1367(c); and (2) the issues raised by the providers in their pending state court suit were different from the issues raised in prior suits that challenged the validity of the AWP statute. *Ark. Blue Cross & Blue Shield v. St. Vincent Infirmary Med. Ctr.*, — F. Supp. 2d —, 2007 U.S. Dist. LEXIS 92101 (E.D. Ark. Dec. 5, 2007).

### **23-99-208. Void provisions.**

(a) To avoid impairment of existing contracts, this subchapter shall only apply to contracts issued or renewed after July 28, 1995.

(b) Any provision in a health benefit plan which is executed, delivered, or renewed, or otherwise contracts for provision of services in this state that is contrary to this subchapter, shall, to the extent of the conflict, be void.

**History.** Acts 1995, No. 505, § 7; 1995, No. 1193, § 4.

### **23-99-209. Applicability.**

The provisions of this subchapter shall not apply to self-funded or other health benefit plans that are exempt from state regulation by virtue of the Employee Retirement Income Security Act of 1974, as amended.

**History.** Acts 1995, No. 1193, § 5.

**U.S. Code.** The Employee Retirement Income Security Act of 1974, as amended, referred to in this section, is codified as 29 U.S.C. § 1001 et seq.

#### **Case Notes**

In General.

#### **In General.**

A permanent injunction barring health care providers who were seeking admittance into an insurer's exclusive provider networks pursuant to the Patient Protection Act was dissolved pursuant to Fed. R. Civ. P. 60(b)(5) after the U.S. Supreme Court held that a similar law in Kentucky was not preempted by ERISA, on the basis that the Supreme Court decision constituted an extraordinary circumstance. *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, — F. Supp.2d —, 2004 U.S. Dist. LEXIS 2906 (E.D. Ark. Feb. 12,

2004), aff'd in part, rev'd in part, 413 F.3d 897 (8th Cir. 2005).

## **Subchapter 8**

### **— Enforcement of any Willing Provider Laws**

23-99-801. Application and intent.

23-99-802. Definitions.

23-99-803. Agency enforcement.

**A.C.R.C. Notes.** Acts 2005, No. 490, the Patient Protection Act of 2005, will not become effective pursuant to section 2 of that act because the 8th Circuit Court of Appeals affirmed the part of the district court ruling that dissolved the permanent injunction barring enforcement of the Patient Protection Act of 1995, § 23-99-201 et seq., as it applies to health insurers of private, insured ERISA plans. See *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, — F. Supp. 2d —, 2004 U.S. Dist. LEXIS 2906 (E.D. Ark. Feb. 12, 2004), aff'd in part, rev'd in part, and remanded, No. 04-1465 (8th Cir. June 29, 2005).

Acts 2005, No. 491, §§ 1 and 2, provided:

**“SECTION 1.** Civil penalties. To the extent permitted by ERISA, the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq., any person adversely affected by a violation of the Patient Protection Act of 2005 may sue in a court of competent jurisdiction for injunctive relief against the health insurer and, upon prevailing, shall, in addition to injunctive relief, recover damages of not less than one thousand dollars (\$1,000), attorney's fees, and costs.

**“SECTION 2.** Validity and construction.

**“(a)** A health benefit plan delivered or issued for delivery to any person in this state in violation of the Patient Protection Act of 2005 but otherwise binding on the health insurer, shall be held valid, but shall be construed as provided in the Patient Protection Act of 2005.

**“(b)** Any health benefit plan or related policy, rider, or endorsement issued and otherwise valid that contains any condition, omission, or provision not in compliance with the requirements of the Patient Protection Act of 2005 shall not be rendered invalid because of the noncompliance, but shall be construed and applied in accordance with such condition, omission, or provision as would have applied if it had been in full compliance with the Patient Protection Act of 2005.”

Acts 2005, No. 491, § 7, provided:

“Sections 3, 4, 5 and 6 of this Act shall take effect and apply to any of the state's any willing provider laws regardless of whether the Patient Protection Act of 2005 becomes effective.”

Acts 2005, No. 960, § 1, provided:

“23-99-207. Civil penalties. To the extent permitted by ERISA, the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq., any provider adversely affected by a violation of this subchapter may sue in a circuit court only for injunctive relief against the health care insurer but not damages. The prevailing party shall be allowed a reasonable attorney's fee and costs.”

Acts 2005, No. 2238, § 2, provided:

**“(4)** ‘Health care provider’ or ‘provider’ means an individual or entity licensed by the State of Arkansas to provide health care services, limited to the following types of providers:

**“(A)** Advanced practice nurses;

- “(B) Athletic trainers;
- “(C) Audiologists;
- “(D) Certified orthotists;
- “(E) Chiropractors;
- “(F) Community mental health centers or clinics;
- “(G) Dentists;
- “(H) Home health care providers;
- “(I) Hospice care providers;
- “(J) Hospital-based services;
- “(K) Hospitals;
- “(L) Licensed ambulatory surgery centers;
- “(M) Licensed certified social workers;
- “(N) Licensed dieticians;
- “(O) Licensed durable medical equipment providers;
- “(P) Licensed professional counselors;
- “(Q) Licensed psychological examiners;
- “(R) Long-term care facilities;
- “(S) Occupational therapists;
- “(T) Optometrists
- “(U) Pharmacists;
- “(V) Physical therapists;
- “(W) Physicians and surgeons (M.D. and D.O.);
- “(X) Podiatrists;
- “(Y) Prosthetists;
- “(Z) Psychologists;
- “(AA) Respiratory therapists;
- “(BB) Rural health clinics;
- “(CC) Speech pathologists; and

“(DD) Other health care practitioners as determined by the department in rules promulgated under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.; and”

**Cross References.** Patient Protection Act of 1995, § 23-99-201 et seq.

**23-99-801. Application and intent.**

(a) The state's any willing provider laws shall not be construed:

(1) To require all physicians or a percentage of physicians in the state or a locale to participate in the provision of services for a health maintenance organization; or

(2) To take away the authority of health maintenance organizations that provide coverage of physician services to set the terms and conditions for participation by physicians, though health maintenance organizations shall apply the terms and conditions in a nondiscriminatory manner.

(b) (1) The state's any willing provider laws shall apply to:

(A) All health insurers, regardless of whether they are providing insurance, including prepaid coverage, or administering or contracting to provide provider networks; and

(B) All multiple-employer welfare arrangements and multiple-employer trusts.

(2) This subsection shall apply only to the extent permitted by ERISA, the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq.

(c) (1) The state's any willing provider laws shall be construed to include within their provider definitions all those providers of the same class or classes who are:

(A) Practicing or operating within a border city in an adjoining state; and

(B) Licensed or authorized to practice or operate by the adjoining state, regardless of whether the provider is licensed or otherwise authorized to operate in Arkansas.

(2) As used in this section, "border city" means a city in a state adjoining Arkansas which adjoins the Arkansas state line and is not separated from an Arkansas city only by a navigable river.

(d) (1) As clarification, nothing in the state's any willing provider laws shall be construed to cover or regulate health care provider networks offered by noninsurers.

(2) If an employer sponsoring a self-insured health benefit plan contracts directly with providers or contracts for a health care provider network through a noninsurer, then the any willing provider law does not apply.

(3) If a health insurer subcontracts with a noninsurer whose health care network does not meet the requirements of the any willing provider law, then the noninsurer may create a separate health care provider network that meets the requirements of the any willing provider law.

(4) If the noninsurer chooses not to create the separate health care provider network, then

the responsibility for compliance with the any willing provider law is the obligation of the health insurer to the extent permitted by ERISA, the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq.

**History.** Acts 2005, No. 491, § 4.

## RESEARCH REFERENCES

### **U. Ark. Little Rock L. Rev.**

Survey of Legislation, 2005 Arkansas General Assembly, Public Health and Welfare, 28 U. Ark. Little Rock L. Rev. 389.

### **23-99-802. Definitions.**

As used in this subchapter:

(1) “Any willing provider law” means a law that prohibits discrimination against a provider willing to meet the terms and conditions for participation established by a health insurer or that otherwise precludes an insurer from prohibiting or limiting participation by a provider who is willing to accept a health insurer's terms and conditions for participation in the provision of services through a health benefit plan;

(2) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq.;

(3) “Health benefit plan” means any health insurance policy or certificate, health maintenance organization contract, hospital and medical service corporation contract or certificate, a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA, the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq., or any health benefit plan that affects the rights of an Arkansas insured and bears a reasonable relation to Arkansas, whether delivered or issued for delivery in Arkansas;

(4) “Health care provider” or “provider” means those individuals or entities licensed by the State of Arkansas to provide health care services, limited to the following:

- (A) Advanced practice nurses;
- (B) Athletic trainers;
- (C) Audiologists;
- (D) Certified orthotists;
- (E) Chiropractors;
- (F) Community mental health centers or clinics;

- (G) Dentists;
- (H) Home health care;
- (I) Hospice care;
- (J) Hospital-based services;
- (K) Hospitals;
- (L) Licensed ambulatory surgery centers;
- (M) Licensed certified social workers;
- (N) Licensed dietitians;
- (O) Licensed durable medical equipment providers;
- (P) Licensed professional counselors;
- (Q) Licensed psychological examiners;
- (R) Long-term care facilities;
- (S) Occupational therapists;
- (T) Optometrists;
- (U) Pharmacists;
- (V) Physical therapists;
- (W) Physicians and surgeons (M.D. and D.O.);
- (X) Podiatrists;
- (Y) Prosthetists;
- (Z) Psychologists;
- (AA) Respiratory therapists;
- (BB) Rural health clinics;
- (CC) Speech pathologists; and

(DD) Other health care practitioners as determined by the department in regulations promulgated under the Arkansas Administrative Procedure Act, § 25-15-201, et seq.;

(5) “Health insurer” or “health care insurer” means any entity that is authorized by the State of Arkansas to offer or provide health benefit plans, policies, subscriber contracts, or any other contracts of a similar nature which indemnify or compensate health care providers for the

provision of health care services;

(6) “Noninsurer” means an entity that is not required to obtain authorization from the department to do business as a health insurer but that does have a provider network; and

(7) “Self-insured” includes self-funded and vice versa.

**History.** Acts 2005, No. 491, § 5; 2005, No. 2238, § 3.

**Amendments.** The 2005 amendment added “Athletic trainers” and alphabetized all subdivisions in (4).

**23-99-803. Agency enforcement.**

The Insurance Commissioner shall:

(1) Enforce the state's any willing provider laws using powers granted to the commissioner in the Arkansas Insurance Code; and

(2) Be entitled to seek an injunction against a health insurer in a court of competent jurisdiction.

**History.** Acts 2005, No. 491, § 3.

**Publisher's Notes.** The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-60-101.

**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").

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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 Intervenor 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 Intervenor”) 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

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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

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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

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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

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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

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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

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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").

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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. Weeks, Chief Executive Officer of the Petitioner; Mike Brown, Chief Operating Officer of ABCBS; Michael Stock, President and CEO of QCA; Lawrence A. Nall, Vice

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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*

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*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.

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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.

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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.

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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

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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* (3<sup>rd</sup> 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* (3<sup>rd</sup> Edition), the phrase, “reimbursement of

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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.

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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

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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

## **EXHIBIT C-1**

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).

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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

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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

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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

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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

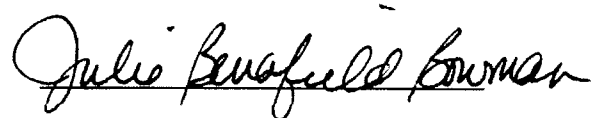
## EXHIBIT C-1

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 15<sup>th</sup> DAY OF SEPTEMBER, 2008.



Julie Benafield Bowman  
Arkansas Insurance Commissioner

**Subchapter 3**  
**— Proceedings — State Insurance Dept.**

- 23-61-301. Examination, investigation, or hearing — Witnesses and evidence.  
 23-61-302. Examination, investigation, or hearing — Testimony compelled — Immunity from prosecution.  
 23-61-303. Hearing — Generally.  
 23-61-304. Hearing — Notice.  
 23-61-305. Hearing — Procedures.  
 23-61-306. Hearing — Order.  
 23-61-307. Hearing — Appeal.

**Effective Dates.** Acts 1987, No. 456, § 31: Mar. 30, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this state concerning the insurance matters covered in the subject of this act are inadequate for the protection of the public and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, and this act being necessary for the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1993, No. 901, § 52: Apr. 6, 1993. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present laws addressed in this omnibus Act on workers' compensation benefits and insurance licensure and other insurance regulatory issues are inadequate for the protection of the Arkansas public and immediate passage of this Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this omnibus Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 1272, § 29: Apr. 13, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present insurance laws, and motor vehicle laws on the automobile assigned risk plan, are inadequate for the protection of the public; and the immediate passage of this Insurance Omnibus Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this Insurance Omnibus Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

**23-61-301. Examination, investigation, or hearing — Witnesses and evidence.**

(a) With respect to the subject of any examination, investigation, or hearing being conducted by the Insurance Commissioner, the commissioner may subpoena witnesses and administer oaths or affirmations and examine any individual under oath and may require and compel the production of records, books, papers, contracts, and other documents.

(b) (1) Witness fees and mileage shall not be allowed as to any licensee of the commissioner.

(2) Witness fees and mileage of persons or entities not licensees of the commissioner, if claimed, shall be allowed the same as for testimony in a circuit court. Provided, however, that

such a claim must be made at the time, date, and place of the hearing to which the person or entity has been summoned, and the amount thereof shall be processed in the same manner as are State Insurance Department employees' requests for expense reimbursement from the State of Arkansas.

(3) Witness fees, mileage, and the actual expense necessarily incurred in securing attendance of witnesses and their testimony shall be itemized and shall be paid by the person being examined or investigated if, in the proceedings in which the witness is called, the person is found to have been in violation of the law, or paid by the person, if other than the commissioner, at whose request the hearing is held.

(c) (1) Subpoenas of witnesses shall be served in the same manner as if issued by a circuit court and may be served by certified mail.

(2) If any individual fails to obey a subpoena issued and served pursuant to this section with respect to any matter concerning which he or she may be lawfully interrogated, upon application of the commissioner, the circuit court of the county in which is pending the proceeding at which the individual was required to appear may issue an order requiring the individual to comply with the subpoena and to testify.

(3) Any failure to obey the order of the court may be punished by the court as a contempt thereof.

(d) If any officer, director, or manager of an insurer has refused, in connection with examination of the insurer by the commissioner, to be examined under oath concerning its affairs, then the commissioner is authorized to conduct and enforce by all appropriate and available means any examination under oath in any state or territory of the United States in which any officer, director, or manager may then presently be to the full extent permitted by the laws of the state or territory, this special authorization considered.

(e) Any person willfully testifying falsely under oath in this state as to any matter material to any examination, investigation, or hearing shall, upon conviction, be guilty of perjury and punished accordingly.

**History.** Acts 1959, No. 148, § 36; A.S.A. 1947, § 66-2121; Acts 1993, No. 901, § 48.

**23-61-302. Examination, investigation, or hearing — Testimony compelled — Immunity from prosecution.**

(a) (1) If any person asks to be excused from attending or testifying or from producing any books, papers, records, correspondence, or other documents at or in connection with any examination, hearing, or investigation being conducted by the Insurance Commissioner or his or her examiner on the ground that the testimony or evidence required of the person may tend to incriminate the person or subject him or her to a penalty or forfeiture and shall, notwithstanding, be directed to give the testimony or produce the evidence, the person must nonetheless comply with the direction, but he or she shall not thereafter be prosecuted or subjected to any penalty or

forfeiture for or on account of any transaction, matter, or thing concerning which he or she may testify or produce evidence pursuant thereto.

(2) No testimony so given or evidence produced shall be received against him or her upon any criminal action, investigation, or proceeding, except that no individual so testifying shall be exempt from prosecution or punishment for any perjury committed by him or her while testifying and the testimony or evidence so given or produced shall be admissible against him or her upon any criminal action, investigation, or proceeding concerning the perjury; nor shall he or she be exempt from the refusal, suspension, or revocation of any license, permission, or authority conferred, or to be conferred, pursuant to the Arkansas Insurance Code.

(b) (1) Any such individual may execute, acknowledge, and file in the State Insurance Department a statement expressly waiving immunity or privilege in respect to any transaction, matter, or thing specified in the statement, and, thereupon, the testimony of the person or the evidence in relation to the transaction, matter, or thing may be received or produced before any judge or justice, court, tribunal, grand jury, or otherwise.

(2) If so received or produced, the individual shall not be entitled to any immunity or privilege on account of any testimony he or she may so give or evidence so produced.

**History.** Acts 1959, No. 148, § 37; A.S.A. 1947, § 66-2122.

**Publisher's Notes.** The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-60-101.

### **23-61-303. Hearing — Generally.**

(a) The Insurance Commissioner may hold hearings for any purpose within the scope of the Arkansas Insurance Code deemed by him or her to be necessary.

(b) (1) The commissioner shall hold a hearing if required by any provision or upon written demand for a hearing by a person aggrieved by any act, threatened act, or failure of the commissioner to act, or by any report, rule, regulation, or order of the commissioner, other than an order for the holding of a hearing, or an order on hearing or pursuant thereto.

(2) Any demand shall specify the grounds to be relied upon as a basis for the relief to be demanded at the hearing, and, unless postponed by mutual consent, the hearing shall be held within thirty (30) days after receipt by the commissioner of the demand.

(c) Pending the hearing and decision thereon, the commissioner may suspend or postpone the effective date of the commissioner's previous action.

**History.** Acts 1959, No. 148, § 38; 1979, No. 942, § 2; A.S.A. 1947, § 66-2123.

**Publisher's Notes.** The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-60-101.

### **Case Notes**

Exhaustion of Remedies.

#### **Exhaustion of Remedies.**

While this section does not require an appellant to seek a hearing before the Insurance Department, if the appellant wishes to seek a declaratory judgment, it must first give the agency the opportunity to address the issue involved, and failure to seek a hearing before the department is clearly a failure to exhaust administrative remedies. *Dynamic Enters. Inc. v. Taylor*, 38 Ark. App. 184, 832 S.W.2d 278 (1992).

#### **23-61-304. Hearing — Notice.**

(a) Not less than ten (10) days in advance, the Insurance Commissioner shall give notice of the time and place of the hearing, stating the matters to be considered at the hearing.

(b) If the persons to be given notice are not specified in the provisions pursuant to which the hearing is held, the commissioner shall give notice to all persons to be directly and immediately affected by the hearing.

**History.** Acts 1959, No. 148, § 39; 1979, No. 942, § 3; A.S.A. 1947, § 66-2124.

### **Research References**

#### **Ark. L. Rev.**

Rules of Evidence in Administrative Proceedings, 15 Ark. L. Rev. 138.

#### **23-61-305. Hearing — Procedures.**

(a) Hearings may be closed to the public at the Insurance Commissioner's discretion, except that a hearing shall be open to the public if so requested in writing by any party to the hearing.

(b) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his or her interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his or her behalf.

(c) The commissioner shall permit to become a party to the hearing by intervention, if timely, only those persons who were not original parties to the hearing and whose pecuniary interests are to be directly and immediately affected by the commissioner's order made upon the hearing.

(d) Formal rules of pleading or evidence need not be observed at any hearing.

(e) (1) Upon written request timely made by a party to the hearing and at that person's expense, the commissioner shall cause a full stenographic record of the proceedings to be made by a competent reporter.

(2) If transcribed, a copy of the stenographic record shall be furnished to the commissioner. Notwithstanding the provisions of the Arkansas Administrative Procedure Act, § 25-15-201 et seq., the transcribed stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing.

(3) If so transcribed, a copy of the stenographic record shall be furnished to any other party to the hearing at the request and expense of the other party.

(4) If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings.

(f) Upon written request of a party to a hearing filed with the commissioner within thirty (30) days after any order made pursuant to a hearing has been mailed or delivered to the persons entitled to receive the order, the commissioner, in his or her discretion, may grant a rehearing or reargument of the matters involved in the hearing, and notice of the rehearing or reargument shall be given as provided in § 23-61-304.

**History.** Acts 1959, No. 148, § 40; 1979, No. 942, § 4; A.S.A. 1947, § 66-2125; Acts 1987, No. 456, § 2.

#### **23-61-306. Hearing — Order.**

(a) In the conduct of any hearing under the Arkansas Insurance Code and making his or her order thereon, the Insurance Commissioner shall act in a quasi-judicial capacity.

(b) Within thirty (30) days after termination of the hearing or of any rehearing thereof or reargument thereon, the commissioner shall make his or her order on hearing, covering matters involved in that hearing and in any rehearing or reargument and shall give a copy of the order to the same persons given notice of the hearing and to all parties to the hearing.

(c) The order shall contain a concise statement of the facts as found by the commissioner and of his or her conclusions from those facts and the matters required by § 23-61-109.

(d) The order may affirm, modify, or nullify action theretofore taken and may constitute the taking of new action within the scope of the notice of hearing.

**History.** Acts 1959, No. 148, § 41; 1979, No. 942, § 5; A.S.A. 1947, § 66-2126.

**Publisher's Notes.** The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-60-101.

#### **Case Notes**

Issuance.

#### **Issuance.**

Fact that life insurer instituted appeal for failure of Insurance Commissioner to enter an order within statutory period after hearing on insurer's financial impairment did not preclude commissioner from entering a final order or render that order void. *First Heritage Life Assurance Co. v. State ex rel. Horne*, 250 Ark. 746, 467 S.W.2d 383 (1971).

#### **23-61-307. Hearing — Appeal.**

(a) An appeal from the Insurance Commissioner shall be taken only from an order on hearing or with respect to a matter as to which the commissioner has refused or failed to grant or hold a hearing after demand therefor under § 23-61-303 or as to a matter as to which the commissioner has refused or failed to make his or her order on hearing as required by § 23-61-306.

(b) Any person who was a party to the hearing, or whose pecuniary interests are directly and immediately affected by the refusal or failure to grant a hearing, and who is aggrieved by the order, refusal, or failure may appeal from the order on hearing or as to any such matter within thirty (30) days after:

(1) The order on hearing has been mailed or delivered to the persons entitled to receive it;

(2) The commissioner's order denying rehearing or reargument has been so mailed or delivered;

(3) The commissioner has refused or failed to make his or her order on hearing as required under § 23-61-306; or

(4) The commissioner has refused or failed to grant or hold a hearing as required under § 23-61-303.

(c) The appeal shall be granted as a matter of right and shall be taken to the Circuit Court of Pulaski County by filing written notice of appeal in the court and by filing a copy of the notice with the commissioner, except that, in appeals from the refusal, suspension, or revocation of the license of an agent, broker, solicitor, or surplus line broker, the person taking the appeal may at his or her option take the appeal to the circuit court of the county in which the person resides instead of to the Circuit Court of Pulaski County.

(d) Upon filing of the notice of appeal therein, the court shall have full jurisdiction and shall determine whether the filing shall operate as a stay of the order or action appealed from and shall

have the right at any time thereafter to issue such other temporary or preliminary orders as to it may seem proper until a final decree is rendered.

(e) Within thirty (30) days after filing of the copy of notice of appeal in his or her office, or within such further time as the court may allow, the commissioner shall make, certify, and deposit in the office of the clerk of the court in which the appeal is pending a full and complete transcript of all proceedings had before the commissioner and all evidence before him or her in the matter, including all his or her files therein.

(f) Upon receipt of the transcript, evidence, and files, the court, as soon as reasonably possible thereafter, shall review the action of the commissioner appealed from.

(g) (1) Any appeal shall be upon the basis of the record so presented.

(2) In any review the findings of the commissioner as to the facts, if supported by substantial evidence, shall be conclusive.

(3) If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that the additional evidence is material and that there were reasonable grounds for the failure to adduce the evidence in the proceedings before the commissioner, the court may order the additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as the court may deem proper.

(4) The commissioner may modify his or her findings of fact or make new findings by reason of the additional evidence taken pursuant to subdivision (g)(3) of this section. The commissioner shall file the modified or new findings, which, if supported by substantial evidence, shall be conclusive, and his or her recommendation, if any, for the modification or setting aside of his or her original order with the return of the additional evidence.

(h) After hearing the appeal the court may affirm, modify, or reverse the order or action of the commissioner in whole or in part, or may remand the action to the commissioner for further proceedings in accordance with the court's direction.

(i) Costs shall be awarded as in civil actions.

(j) (1) Appeal may be taken to the Arkansas Supreme Court or the Arkansas Court of Appeals from the judgment of the circuit court as in other civil cases.

(2) The circuit court judgment appealed from shall not be subject to supersedeas, and a stay of the effectiveness of any judgment may be made only by order of the Arkansas Supreme Court or the Arkansas Court of Appeals upon the giving of such security as the court deems proper.

**History.** Acts 1959, No. 148, § 42; 1979, No. 942, § 6; A.S.A. 1947, § 66-2127; Acts 1987, No. 456, § 3; 1995, No. 1272, § 5.

## **Case Notes**

Final Orders.  
Scope of Review.

### **Final Orders.**

Fact that life insurer instituted appeal for failure of Insurance Commissioner to enter an order within statutory period after hearing on insurer's financial impairment did not preclude commissioner from entering a final order or render that order void. *First Heritage Life Assurance Co. v. State ex rel. Horne*, 250 Ark. 746, 467 S.W.2d 383 (1971).

### **Scope of Review.**

The circuit court had power to modify certificate required by the commissioner to be executed by the principal officers of each insurer in connection with the commissioner's examination of such insurers, without impairing the commissioner's power to make regulations or prescribe certificates within the limits permitted by law. *Arkansas Ins. Comm'r v. Christian Found. Life Ins. Co.*, 248 Ark. 1184, 455 S.W.2d 878 (1970).

**Cited:** *Douglas v. Dynamic Enters., Inc.*, 315 Ark. 575, 869 S.W.2d 14 (1994).

**Subchapter 1**  
**— General Provisions - State Insurance Dept.**

- 23-61-101. State Insurance Department — Continuation — Assignment of space.
- 23-61-102. Insurance Commissioner.
- 23-61-103. Insurance Commissioner — Powers and duties.
- 23-61-104. Deputies, assistants, and other employees — Appointment — Duties.
- 23-61-105. Commissioner, deputies, assistants, and other employees — Expense allowance.
- 23-61-106. Commissioner, deputies, assistants, and other employees — Financial interest prohibited — Exception.
- 23-61-107. Records.
- 23-61-108. Rules and regulations.
- 23-61-109. Orders and notices.
- 23-61-110. Enforcement generally.
- 23-61-111. Enforcement — Foreign decrees.
- 23-61-112. Annual report.
- 23-61-113. Disclosure of nonpublic personal information.
- 23-61-114. Annual report regarding malpractice rates.
- 23-61-115. Policyholder's Bill of Rights.

**A.C.R.C. Notes.** Acts 2003 (2nd Ex. Sess.), No. 78, § 1, provided:

“Purpose.

**(a)** The purpose of this act is to provide for the administration and regulation of the Public Elementary and Secondary School Insurance Program and the School Motor Vehicle Insurance Program by the State Insurance Department and to amend various provisions of Arkansas Code §§ 6-20-1501 to 6-20-1515 and §§ 6-21-701 to 6-21-711. The responsibilities of the Department of Education for the regulation and administration of the Public Elementary and Secondary School Self-Insurance Program and the School Motor Vehicle Self-Insurance Program shall cease and its responsibilities shall be transferred to the State Insurance Department. The programs shall be known as the Public Elementary and Secondary School Insurance Program and the Public School Motor Vehicle Insurance Program.

**“(b)** The statutory authority, powers, duties, functions, including budgeting and purchasing, records, property, unexpended balances of appropriations, allocations, or other funds, and authorized positions but not the personnel of the Public Elementary and Secondary School Self-Insurance Program and the School Motor Vehicle Self-Insurance Program are transferred to the department. The transfer shall include each program’s prescribed powers, duties, and functions, including but not limited to rulemaking, regulation, and licensing; and the rendering of findings, orders and adjudications.

**“(c)** All forms for the administration and regulation of the programs, all trust agreements and arrangements, and all documents presently in use which have been previously approved by the Department of Education or the State Board of Education shall continue to be approved until otherwise determined by the Insurance Commissioner.

**“(d)** The Insurance Services Division of the Department of Education is transferred to the State Insurance Department by a type two (2) transfer under § 25-2-105. The transfer shall include the authorized positions but shall not include the personnel of the division.”

**Effective Dates.** Acts 1987, No. 456, § 31: Mar. 30, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this state concerning the insurance matters covered in the subject of this act are inadequate for the protection of the public and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, and this act being necessary for the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1991, No. 723, § 33: Mar. 25, 1991. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 1272, § 29: Apr. 13, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present insurance laws, and motor vehicle laws on the automobile assigned risk plan, are inadequate for the protection of the public; and the immediate passage of this Insurance Omnibus Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this Insurance Omnibus Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 2001, No. 538, § 2: Mar. 1, 2001. Emergency clause provided: "It is hereby found and determined by the Eighty-third General Assembly, that there is an immediate need for the Insurance Department to enter into agreements for the sharing and receiving of confidential information from other governmental entities in order to further enhance the regulatory capabilities of the department and to comply with Gramm-Leach-Bliley. 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 the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2001, No. 1239, § 3: Apr. 2, 2001. Emergency clause provided: "It is found and determined by the General Assembly that sweeping changes are occurring in financial services both nationally and internationally; that Arkansas consumers should have access to the most choices and the most sophisticated products in the modern marketplace while being protected from mistreatment in the marketplace; that this act shall be broadly construed to effect these purposes; and that this act is immediately necessary to enhance the ability of this state to efficiently and effectively regulate the business of insurance by authorizing the State Insurance Commissioner to coordinate regulatory activities and administration with other states and their appropriate regulatory officials and with the federal government with respect to the regulation of insurance. 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 the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2001, No. 1619, § 2: Apr. 16, 2001. Emergency clause provided: "It is hereby found and determined by the Eighty-third General Assembly that there is an immediate need for the Insurance Commissioner to enact regulations providing for the treatment of nonpublic financial and health information by licensees. Such action is in the best interest of the public, in that such regulations will protect the public's personal nonpublic financial and health information, and will also assist the states in achieving uniformity in the regulation of the insurance business. 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 the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2005, No. 506, § 54: Mar. 2, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the laws of this state as to insurance regulation and the Governmental Bonding Board, among others, are inadequate for the protection of the public, and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. 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."

### **23-61-101. State Insurance Department — Continuation — Assignment of space.**

(a) There is continued at the seat of government of this state an office or department designated as the State Insurance Department.

(b) Suitable space shall be assigned for the use of the department.

(c) (1) (A) The purpose of the department is to serve and protect the public interest by the equitable enforcement of the state's laws and regulations affecting the insurance industry.

(B) The primary mission of the department shall be consumer protection through insurer solvency and market conduct regulation, and fraud prosecution and deterrence.

(2) Nothing in this subsection shall be construed to limit the Insurance Commissioner's authority as enumerated in other provisions of the Arkansas Insurance Code.

**History.** Acts 1959, No. 148, § 16; A.S.A. 1947, § 66-2101; Acts 2001, No. 610, § 1.

**A.C.R.C. Notes.** Acts 2007, No. 684, § 1, provided: "Effective January 1, 2008, the Arkansas Title Insurance Agents' Licensing Board established by the Arkansas Title Insurance Agents' Licensing Act, § 23-103-101 et seq., is abolished and its powers and duties are transferred to the State Insurance Department by a type 3 transfer under § 25-2-106. The transfer shall include the authorized positions of the board but shall not include the personnel of the board."

**Publisher's Notes.** The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-60-101.

Acts 1971, No. 38, § 16, transferred the State Insurance Department into the Department of Commerce. However, Acts 1983, No. 691 abolished the Department of Commerce, and § 4 of that act provided that the State Insurance Department should be an independent agency and should function in the same manner as it functioned prior to its transfer to the Department of Commerce.

**Amendments.** The 2001 amendment added (c).

### **23-61-102. Insurance Commissioner.**

(a) The head of the State Insurance Department shall be an Insurance Commissioner appointed by the Governor with the advice and consent of the Senate. No person shall be eligible for appointment as commissioner unless a citizen of this state and at least thirty (30) years of age.

(b) The term of office of the commissioner shall be for a period of four (4) years, commencing on January 15 next following expiration of the previous four-year term. A person who has been commissioner is eligible for reappointment for additional terms.

(c) The commissioner shall take and subscribe to the usual oath of office.

(d) The commissioner shall receive the salary provided by law.

(e) (1) At the time of taking office, the commissioner shall execute bond to the State of Arkansas in the sum of fifty thousand dollars (\$50,000) for the faithful performance of his or her duties.

(2) The form and surety of the bond shall be subject to the approval of the Governor and Auditor of State.

(3) An authorized surety insurer shall be the surety on the bond.

(f) (1) The commissioner shall have an official seal.

(2) All certificates issued by the commissioner shall bear his or her seal.

(3) Every document executed by the commissioner pursuant to law and bearing his or her official seal shall be received as evidence in any court or other tribunal and may be recorded in the same manner and with like effect as deeds regularly acknowledged.

**History.** Acts 1959, No. 148, §§ 17, 18; A.S.A. 1947, §§ 66-2102, 66-2103.

**A.C.R.C. Notes.** The operation of subsection (e) of this section was suspended by adoption of a self-insured fidelity bond program for public officers, officials and employees, effective July 20, 1987, pursuant to § 21-2-701 et seq. The subsection may again become effective upon cessation of coverage under that program. See § 21-2-703.

### **23-61-103. Insurance Commissioner — Powers and duties.**

(a) The Insurance Commissioner shall enforce the provisions of the Arkansas Insurance Code and shall execute the duties imposed upon him or her by the Arkansas Insurance Code.

(b) The commissioner shall have the powers and authority expressly conferred upon him or her by or reasonably implied from the provisions of the Arkansas Insurance Code.

(c) The commissioner is authorized to enter into regulatory cooperation and coordination agreements with other governmental regulatory agencies within and outside of this state with respect to the regulation of the business of insurance, including, but not limited to:

- (1) Licensing of insurance companies;
- (2) Licensing of producers;
- (3) Regulation of premium rates and policy forms;
- (4) Regulation of insurer solvency and insurance receiverships; and
- (5) Other matters relating to the effective regulation of the business of insurance.

(d) (1) The commissioner may conduct such examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as he or she may deem proper to determine whether any person has violated any provision of the Arkansas Insurance Code or to secure information useful in the lawful administration of any such provision. The cost of these additional examinations or investigations shall be borne by the state.

(2) Notwithstanding any other provision of law, active investigatory or examination files as maintained by the State Insurance Department shall be deemed confidential and privileged and shall not be made open to the public until:

(A) The matter under investigation or examination is deemed closed by the commissioner; or

(B) Referred to any law enforcement authority and made subject to public disclosure by the authority.

(3) At such time that any matter investigated or examined has been set for an administrative hearing pursuant to § 23-61-304 or § 25-15-208, investigation or examination information shall be made available as provided in § 25-15-208.

(4) Unless otherwise exempted by subdivision (d)(5) of this section, actuarial formulas and assumptions certified by a qualified actuary are confidential and privileged when submitted to comply with a rate or form filing requirement of the department, including, but not limited to, any actuarial report:

(A) Required, submitted, or attached to any filing made to the department under § 23-67-211, for rate and form filings of an insurer, or to those submitted under § 23-63-216 for annual statements of an insurer; or

(B) Submitted to the department to comply with any form and rate filing requirement imposed by statute or rule upon licensed insurers, health maintenance organizations, fraternal benefit societies, and hospital and medical service corporations.

(5) (A) Subdivisions (d)(2) and (d)(4) of this section do not prohibit release by the

commissioner of active investigatory or examination files:

(i) At the discretion of the commissioner, to a person or persons that the commissioner determines to be aggrieved or affected by the examination or investigation; or

(ii) To state, federal, or local law enforcement or regulatory agencies or private organizations established for tracking or preventing insurance violations, or to the National Association of Insurance Commissioners.

(B) This section shall have no effect on or application to any of the filings gathered or compiled in compliance with § 23-63-1201 et seq.

(6) Release of active investigatory or examination files as provided in subdivision (d)(4) of this section does not abrogate or modify the confidential nature of investigatory or examination files as provided in subdivision (d)(2) of this section.

(e) (1) The commissioner may delegate to any assistant, deputy, examiner, or employee of the department the exercise or discharge in the commissioner's name of any power, duty, or function, whether ministerial, discretionary, or of whatever character which may be vested by the Arkansas Insurance Code in the commissioner.

(2) The commissioner shall be responsible for the official acts of his or her deputy, assistant, examiner, or employee acting in the commissioner's name and by his or her authority.

**History.** Acts 1959, No. 148, §§ 22, 25; A.S.A. 1947, §§ 66-2107, 66-2110; Acts 1997, No. 956, § 1; 1999, No. 453, § 1; 2001, No. 1239, § 2.

**A.C.R.C. Notes.** Acts 2007, No. 684, § 1, provided: "Effective January 1, 2008, the Arkansas Title Insurance Agents' Licensing Board established by the Arkansas Title Insurance Agents' Licensing Act, § 23-103-101 et seq., is abolished and its powers and duties are transferred to the State Insurance Department by a type 3 transfer under § 25-2-106. The transfer shall include the authorized positions of the board but shall not include the personnel of the board."

**Publisher's Notes.** The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-60-101.

**Amendments.** The 1999 amendment rewrote (c)(4); inserted present (c)(5) and redesignated former (c)(5) as present (c)(6); and made stylistic changes.

The 2001 amendment rewrote the section.

**Cross References.** Suspension, etc., of agent's or company's license for Insurance Code violations, § 23-60-108.

### Research References

#### U. Ark. Little Rock L. Rev.

Survey of Legislation, 2001 Arkansas General Assembly, Insurance Law, 24 U. Ark. Little Rock L. Rev. 577.