Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

State of Arkansas *As Engrossed: S3/7/01 S3/13/01 S3/15/01*
83rd General Assembly **A Bill**
Regular Session, 2001 SENATE BILL 984

By: Senators DeLay, *B. Walker*
By: *Representative Bledsoe*

For An Act To Be Entitled

AN ACT TO PROTECT THE PATIENT-PROVIDER RELATIONSHIP BY ESTABLISHING DUE PROCESS REQUIREMENTS TO BE FOLLOWED BY HEALTH CARRIERS WHEN TERMINATING PROVIDERS FROM PARTICIPATION IN HEALTH CARE PLANS; AND FOR OTHER PURPOSES; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO ESTABLISH DUE PROCESS REQUIREMENTS TO BE FOLLOWED BY HEALTH CARRIERS WHEN TERMINATING PROVIDERS FROM PARTICIPATION IN HEALTH CARE PLANS.

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

SECTION 1. Title.

This act shall be known and cited as the "Patient-Provider Protection Act."

SECTION 2. Definitions.

For purposes of this act:

(1)(A) "Health care plan" or "health plan" means any individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a carrier in this state, including indemnity and managed care plans and including governmental and church plans as defined in 29 U.S.C. §1002, existing on January 1, 2001.

(B) "Health care plan" does not mean a plan that provides coverage only for:

(i) A specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as in the Long-Term Care Insurance Act, vision care or any other limited supplemental benefit;

(ii) A Medicare supplement policy of insurance, as defined by the Insurance Commissioner by regulation;

(iii) Coverage under a plan through Medicare, Medicaid, or the Federal Employees Health Benefit Program;

(iv) Any coverage issued under Chapter 55 of Title 10 of the U.S. Code, existing on January 1, 2001, and any coverage issued as supplemental to that coverage;

(v) Any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance; and

(vi) Automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault;

(2) "Health carrier" or "carrier" means any accident and health insurance company, referred to in law as "disability" insurance company, hospital and medical services corporation, or health maintenance organization issuing or delivering health benefit plans in this state;

(3) "Participating provider" means a provider who has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health care insurer;

(4)(A)(i) "Cause" means actions or omissions which adversely affect quality of care, violate professional standards, or violate reasonable administrative practices.

(ii) "Cause" may include acts or omission for which the provider could be disciplined by a regulatory authority of this state, malpractice, substandard care, overutilization, underutilization, fraud, and violations of the terms of the provider contract.

(B) However, the terms of the provider contract must be specific and reasonable and not designed to circumvent this act.

SECTION 3. Termination of participating providers.

(a)(1) No participating provider shall be terminated or nonrenewed from a health care plan except for cause.

(2) Notwithstanding any other provision in this act, nothing shall prevent a health carrier from terminating or nonrenewing a participating provider outside the provisions of this act if the carrier withdraws its business from the geographic area or the state or if the carrier ceases to offer the type of health care service provided by a participating provider.

(3) It shall not be a violation of this act to terminate or nonrenew a provider who is unwilling to provide services at the applicable reimbursement rate.

(4) Prior to terminating or nonrenewing any health care provider from participation in the managed care plan, the health carrier shall give the provider notice by certified mail, stating the reasons for the termination or nonrenewal and setting forth the appeals process described in this act.

(b) The existence of a termination without cause or any other provision in a carrier's contract with a provider shall not supersede the requirements of this act.

(c) The notice of the proposed contract termination or nonrenewal provided by the insurer to the participating provider shall include:

(1) The reason or reasons for the proposed action in sufficient detail to permit the provider to respond;

(2)(A) Reference to the evidence or documentation underlying the carrier's decision to pursue the proposed action.

(B) A carrier shall permit a provider to review this evidence and documentation upon request;

(3) Notice that the provider has the right to request a review hearing before a panel appointed by the carrier;

(4) A time limit of at least thirty (30) days from the date the provider receives the notice within which a provider may request a review hearing; and

(5) A time limit for a hearing date that shall be at least thirty (30) days after the date of receipt of a request for a hearing.

(d) Termination or nonrenewal may not be effective earlier than sixty (60) days from the receipt of the notice of termination or nonrenewal.

(e)(1) A hearing panel shall be composed of at least three (3) persons appointed by the carrier and two (2) of the three (3) members shall be a clinical peer in the same discipline and the same specialty of the provider under review.

(2) A hearing panel may be composed of more than three (3) persons if the number of clinical peers on the hearing panel constitutes two-thirds (2/3) or more of the total membership of the panel.

(3) No person serving on the panel may be employed by, have a family member employed by, be a consultant for, or have a financial interest in, the carrier, other than participating provider status, or otherwise have a conflict of interest.

(f) The provider shall be afforded the opportunity to appear at the hearing.

(g)(1) A hearing panel shall render a written decision on the proposed action in a timely manner.

(2) This decision shall be either the reinstatement of the provider by the carrier, the provisional reinstatement of the provider subject to conditions established by the carrier, or the termination or nonrenewal of the provider.

(h) A decision by a hearing panel to terminate or nonrenew a contract with a provider may not become effective less than sixty (60) days after the receipt of the provider of the hearing panel's decision or until the termination date in the provider's contract, whichever is earlier.

(i) A determination by the hearing panel shall be binding on the health carrier and the provider except to the extent that either has other available remedies under applicable federal or state law. The decision of the hearing panel shall not be admissible in any other proceeding.

SECTION 4. Section 3 of this act shall apply to all provider contracts issued, renewed, extended or modified by a health carrier on or after the effective date of this act. "Renewed, extended, or modified" includes but is not limited to a change in reimbursement rates or other financial terms.

SECTION 5. Health carriers shall not use economic coercion to force any participating health care provider to move the location of the provider's practice or facility.

SECTION 6. Enforcement.

(a) If a carrier violates the notice and hearing requirements of section 3 of this act, a participating provider may file suit for injunctive relief in a court of competent jurisdiction and, upon prevailing, be entitled to reasonable attorney fees and costs.

(b) Any person adversely affected by a violation of section 5 of this act may sue in a court of competent jurisdiction for injunctive relief against the health carrier and, upon prevailing, shall, in addition to the relief, recover damages not less than one thousand dollars ($1,000) plus attorney's fees and costs.

(c)(1) The Insurance Commissioner may enforce this act through the powers granted to the commissioner in the Arkansas Insurance Code, which begins at Arkansas Code 23-60-101.

(2) Violation of this act shall be grounds for suspending or revoking any license, permit, certification, or other authority to practice or conduct business in this state.

SECTION 7. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

SECTION 8. The General Assembly expressly declares that in the event any portion of this act is found to be preempted or otherwise in violation of federal law, that the provisions of this act are to be considered independent and not inextricably linked.

SECTION 9. Legislative findings and purposes.

The General Assembly finds that health carriers and providers both serve essential functions in the health care market of this state. However, because of the dramatic changes in the health care market, carriers have come to enjoy superior bargaining power. Terminating a provider from a carrier's network can significantly impair the ability of the provider to practice medicine or other profession in that geographic area, thereby affecting an

important substantial economic interest. But the removal of a provider from a participating provider list affects more than the provider's interest. It affects the patient. There is a unique tripartite relationship among carriers, their insureds, and the participating providers. The public has a substantial interest in seeing that the relationships between patients and providers are not unduly interrupted and that patients continue to enjoy access to quality health care. The due process protections contained in this act are designed to protect the public interest by regulating the manner in which carriers terminate their agreements with providers who provide care to the insureds and enrollees.

/s/ DeLay