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
86th General Assembly
Regular Session, 2007

A Bill

HOUSE BILL 2627

By: Representative Wills

For An Act To Be Entitled

AN ACT TO REQUIRE SUBSCRIBER IDENTIFICATION CARDS TO IDENTIFY ANY NETWORK DISCOUNTS THAT WILL APPLY TO PROVIDER CLAIMS; AND FOR OTHER PURPOSES.

Subtitle

TO REQUIRE FULL DISCLOSURE REGARDING WHICH ENTITIES HAVE ACCESS TO PROVIDER NETWORKS.

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

SECTION 1. Arkansas Code Title 23, Chapter 63, Subchapter 1 is amended to add an additional section to read as follows:

23-63-113. Agreement required for access to contracting agent's panel of contracted health care providers or contracted reimbursement rates -- Identification of network discounts applicable to provider claims required on subscriber identification cards.

(a) As used in this section:

(1)(A) "Contracting agent" means an entity that while engaged in selling, leasing, assigning, conveying, or otherwise, grants access to the entity's panel of contracted health care providers and the entity's contracted reimbursement rates to another entity.

(B) "Contracting agent" includes, to the extent an entity is engaged in the activities in subdivision (a)(1)(A) of this section and to the full extent permitted by the Federal Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., as it existed on January 1, 2007.

(i) Preferred provider organizations;

(ii) Third-party administrators;

(iii) Prescription benefit management companies;

(iv) Insurance companies;

(v) Health maintenance organizations;

(vi) Hospital and medical service corporations; and

(vii) Self-insured health plans;

(2) "Entity" means any physician or other provider of health care services, including institutional providers and organizations or groups of health care providers;

(3)(A) "Health benefit plan" means any individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a health care insurer in this state, including indemnity and managed care plans and governmental plans as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2007.

(B) "Health benefit plan" does not include plans providing health care services under the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(4) "Person" means an individual, a corporation, a partnership, a firm, a trust, an association, a voluntary organization, or any other form of business enterprise or legal entity;

(5) "Provider" means any physician or other provider of health care services, including institutional providers, and also organizations or groups of health care providers;

(6) "Provider network" means a preferred provider organization or any other network of providers; and

(7) "Subscriber identification card" or "identification card" means a card that is issued to an individual evidencing his or her coverage under a health benefit plan.

(b)(1) No contracting agent shall sell, lease, assign, convey, or otherwise grant access to the contracting agent's panel of contracted health care providers or the contracting agent's contracted reimbursement rates to another entity unless authorized in an agreement between the contracting agent and the provider.

(2) At least annually and upon written request of a contracted provider, a contracting agent shall disclose to its providers all payors and other entities to which the contracting agent has sold, leased, assigned,

conveyed, or otherwise granted access to the contracting agent's panel of contracted health care providers and the contracting agent's reimbursement rates.

(c)(1) A subscriber identification card shall state, in a clear and legible manner, the entity responsible for processing claims for payment if different from the payor.

(2) A provider network's contractual discounts or other alternative rates of payments shall not be enforceable or binding upon a provider unless the provider network is clearly identified on the subscriber identification card presented to the provider when medical care is provided.

(d) This section does not apply to an insurance company, a health maintenance organization, or any other entity when the insurance company, the health maintenance organization, or the other entity provides health benefits directly through the insurance company's, the health maintenance organization's, or the other entity's own network to the insurance company's, the health maintenance organization's, or other entity's own enrollees without using a contracting agent.

(e) No contracting agent shall retaliate against a provider for exercising rights under this section.

(f) The Insurance Commissioner shall adopt rules for the implementation, administration, and enforcement of this section.

(g) Upon finding that a contracting agent, a payor, or another entity has violated this section, the commissioner:

(1) May issue a cease and desist order to prevent further violation of this section; and

(2) Shall impose a fine of no less than one thousand dollars ($1,000) and no greater than one million dollars ($1,000,000).

(h) Nothing in any contract shall supersede this section.

(i)(1) To avoid impairment of existing contracts, this section shall only apply to contracts issued, renewed, or amended after the effective date of this section.

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