

Stricken language would be deleted from and underlined language would be added to present law.

State of Arkansas  
93rd General Assembly  
Regular Session, 2021

# A Bill

SENATE BILL 198

By: Senator K. Hammer  
By: Representative Gonzales

## For An Act To Be Entitled

AN ACT TO ESTABLISH THE PATIENT CREDIT PROTECTION  
ACT; AND FOR OTHER PURPOSES.

### Subtitle

TO ESTABLISH THE PATIENT CREDIT  
PROTECTION ACT.

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

SECTION 1. TEMPORARY LANGUAGE. DO NOT CODIFY. Legislative findings.  
The General Assembly finds that:

- (1) Almost twenty percent (20%) of individuals receiving emergency healthcare services receive a balanced bill;
- (2) Many individuals have received a medical bill for healthcare services that is higher than expected because the individual receiving those healthcare services did not know the full price ahead of time;
- (3) Prices for the same healthcare services received from different healthcare providers may differ by thousands of dollars;
- (4) A healthcare provider often has no idea that a patient is struggling with the high costs of healthcare services;
- (5) A patient has few options to contest an unreasonably high medical bill;
- (6) An individual's credit can be impaired as a result of an unpaid balance bill, even if the individual did everything right such as receiving healthcare services through an in-network facility and paying the associated out-of-pocket obligations under a health benefit plan;



(7) In 2014, at least forty-three million (43,000,000) Americans had overdue medical debt on their consumer reports, and for fifteen million (15,000,000) of those Americans, medical debt was the only impairment on their consumer report;

(8) Credit impairments may remain on a consumer report even after an individual has paid off a bill; and

(9) Credit impairment due to medical debt can significantly impact the economic future of individuals in Arkansas and the state’s economy as individuals continue to struggle economically for years as a result.

SECTION 2. Arkansas Code Title 4, Chapter 93, is amended to add an additional subchapter to read as follows:

Subchapter 2 – Patient Credit Protection Act

4-93-201. Title.

This subchapter shall be known and may be cited as the "Patient Credit Protection Act".

4-93-202. Definitions.

As used in this subchapter:

(1)(A) "Covered person" means a person who is and continues to remain eligible for coverage under a health benefit plan and is covered under the health benefit plan.

(B) "Covered person" includes a policyholder, subscriber, participant, or other individual covered by a health benefit plan;

(2)(A) "Health benefit plan" means an individual, blanket, or any group plan, policy, or contract for healthcare services issued, renewed, or extended in this state by a healthcare insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state.

(B) "Health benefit plan" includes:

(i) Indemnity or managed care plans; and

(ii) Plans providing health benefits to state and

public school employees under § 21-5-401 et seq.

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

(i) A disability income plan;

- (ii) A credit insurance plan;
- (iii) Insurance coverage issued as a supplement to liability insurance;
- (iv) Coverage for medical expenses under an automobile or homeowners insurance plan;
- (v) Coverage or payments provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;
- (vi) A plan that provides only indemnity for hospital confinement;
- (vii) An accident-only plan; or
- (viii) A specified disease plan;

(3)(A) "Healthcare provider" means a person or entity that is licensed, certified, or otherwise authorized by the laws of this state to provide healthcare services.

(B) "Healthcare provider" includes any third-party entity employed to collect medical debt owed by a covered person on behalf of a healthcare provider for healthcare services;

(4) "Healthcare services" means services or goods provided for the purpose of or related to the purpose of preventing, diagnosing, or treating a human illness, disease, condition, disability, or injury;

(5) "Medical debt" means the outstanding balance owed to a healthcare provider for healthcare services;

(6) "Original healthcare provider" means the initial healthcare provider that provided healthcare services to a covered person;

(7) "Outstanding balance" means the amount owed by a covered person for healthcare services after payment of a covered person's copayments, deductibles, and coinsurance, or as part of a payment plan; and

(8) "Periodic payment plan" means an arrangement between a consumer and a healthcare provider to settle an outstanding balance owed for medical debt.

4-93-203. Credit protection for covered persons – Right of action.

(a) Negative financial information shall not be reported by a healthcare provider to a consumer reporting agency or published for a consumer if the collection process or billing is for:

(1) A patient who is a covered person at the time healthcare services are provided; and

(2) An outstanding balance for a medical debt after the consumer's share of copayments, deductibles, and coinsurance owed for healthcare services have been paid or are being paid as part of a periodic payment plan.

(b) An outstanding balance for a medical debt for a covered person shall not be reported by a healthcare provider to a consumer reporting agency without the express written consent of the original healthcare provider, or another healthcare provider at that location if the original healthcare provider no longer works at that location.

(c) When notified that a medical debt incurred by an individual for payment for healthcare services has been paid in full or that the consumer is actively participating in a periodic payment plan, any impairment on a consumer report resulting from that medical debt shall be removed within thirty (30) days.

#### 4-93-204. Penalties – Civil.

(a)(1) A healthcare provider that provides healthcare services to a covered person is subject to a private right of action by a covered person if the healthcare provider purposely:

(A) Charges an unconscionably excessive amount of money for healthcare services to a covered person under a health benefit plan; and

(B) The covered person suffers a loss as a result of a violation of this subchapter.

(2)(A) A covered person may initiate a civil action to remove any resulting credit impairment and recover actual damages or one thousand five hundred dollars (\$1,500), whichever is greater.

(B)(i) All parties may agree upon an arbitrator to resolve the medical debt dispute.

(ii) If an arbitrator finds that a violation of this subchapter was willful, then the arbitrator may increase the damages to an amount that does not exceed three (3) times the actual damages sustained or five thousand dollars (\$5,000), whichever is greater.

(b) A violation of this subchapter constitutes an unfair and deceptive act or practice, as defined by the Deceptive Trade Practices Act, § 4-88-101

et seq.

(c) The Attorney General may bring a civil cause of action under this subchapter on behalf of a covered person who has been charged an unconscionable excessive amount of money for healthcare services by a healthcare provider.

(d) Notwithstanding any other law, in addition to any damages awarded under subsections (a) and (b) of this section, a prevailing party in a cause of action under this subchapter is entitled to reasonable costs and attorney's fees, not to exceed five (5) times the damages awarded and court costs.

4-93-205. Action.

A legal action brought under this subchapter shall commence within two (2) years from the date the covered person challenges the validity of the debt for healthcare services.

4-93-206. Rules.

The Insurance Commissioner shall promulgate rules necessary to implement this subchapter.

SECTION 3. DO NOT CODIFY. Effective date.

This subchapter is effective on and after January 1, 2022.

SECTION 4. DO NOT CODIFY. Rules.

(a) When adopting the initial rules required under this act, the Insurance Commissioner shall file the final rules with the Secretary of State for adoption under § 25-15-204(f):

(1) On or before January 1, 2022; or

(2) If approval under § 10-3-309 has not occurred by January 1, 2022, as soon as practicable after approval under § 10-3-309.

(b) The commissioner shall file the proposed rules with the Legislative Council under § 10-3-309(c) sufficiently in advance of January 1, 2022, so that the Legislative Council may consider the rules for approval before January 1, 2022.