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Subchapter 1. General Provisions.

[Reserved]

Subchapter 2. Patient Protection Act.

23-99-201. Short title.

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

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.

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, Act 796 of 1993, 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) Physicians and surgeons (M.D. and D.O.);
 - (2) Podiatrists;
 - (3) Chiropractors;
 - (4) Physical therapists;
 - (5) Speech pathologists;
 - (6) Audiologists;
 - (7) Dentists;
 - (8) Optometrists;
 - (9) Hospitals;
 - (10) Hospital-based services;
 - (11) Psychologists;
 - (12) Licensed professional counselors;
 - (13) Respiratory therapists;
 - (14) Pharmacists;
 - (15) Occupational therapists;
 - (16) Long-term care facilities;
 - (17) Home health care;
 - (18) Hospice care;
 - (19) Licensed ambulatory surgery centers;
 - (20) Rural health clinics;
 - (21) Licensed certified social workers;
 - (22) Licensed psychological examiners;
 - (23) Advanced practice nurses;
 - (24) Licensed dieticians;
 - (25) Community mental health centers or clinics;
 - (26) Certified orthotists; and
 - (27) Prosthetists.
- (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 services 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.

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.

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.

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.

23-99-207. Civil penalties.

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

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.

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 federal Employee Retirement Income Security Act of 1974, as amended.

**Subchapter 3.
Primary Eye Care Provider Act.**

23-99-301. Short title.

This subchapter shall be known and may be cited as the "Primary Eye Care Provider Act".

23-99-302. Definitions.

As used in this subchapter:

- (1) "Covered persons" means any individual or family that is enrolled in a health benefit plan or policy from a health care insurer and on whose behalf the health care insurer is obligated to pay for or provide eye and/or vision care services;
- (2) "Covered service" means those health care services, including eye and/or vision care services, which the health care insurer is obligated to pay for or provide to covered persons under the health benefit plan or policy;
- (3)(A) "Eye and/or vision care benefits" means those services and materials which are provided by a primary eye care provider who is functioning within the scope of his or her license.
- (B) The conditions imposed by any specific health benefit plan upon the provision of eye and/or vision care benefits shall not:
 - (i) Prohibit the primary eye care provider from providing covered services to covered persons at his or her highest level of licensure and competence at any given time, as determined by his or her respective licensing board; or
 - (ii) Require that the primary eye care provider hold hospital staff privileges or include any other condition as a requirement which would have the practical effect of excluding any class of provider from participation in the

- plan;
- (4) "Gatekeeper" means a covered person's primary care provider in a gatekeeper system;
 - (5) "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;
 - (6) "Health benefit plan" means any public or private health plan, program, policy, subscriber agreement, or contract implemented in the State of Arkansas which includes or may include payment, reimbursement, including capitation, or financial compensation for provision of eye and/or vision care benefits to covered persons, but does not include workers' compensation coverage or reimbursement;
 - (7) "Health care insurer" means any entity, including, but not limited to, insurance companies, hospital and medical services corporations, health maintenance organizations, preferred provider organizations, and physician hospital organizations, 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; and
 - (8) "Primary eye care provider" means an ophthalmologist or optometrist licensed by the State of Arkansas who has been selected by a person covered by a health benefit plan to provide eye and/or vision care services and who agrees to provide these services in accordance with the terms, conditions, reimbursement rates, and standards of quality as set forth within the specific health benefit plan.

23-99-303. Requirements for health benefit plans.

A health benefit plan that includes, or may include, eye and/or vision care benefits shall:

- (1) Include all primary eye care providers who are selected by covered persons of the plan for the provision of all eye and/or vision care benefits provided by the plan;
- (2) Permit any licensed optometrist or ophthalmologist who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a primary eye care provider to any person covered by that plan;
- (3) Guarantee that all covered persons who are eligible for eye and/or vision care benefits under a health benefit plan shall have direct access to the primary eye care provider of their choice independent of, and without referral from, any other provider or entity;
- (4)(A) Assure that those plans utilizing a gatekeeper system shall designate the primary eye care provider as the gatekeeper who shall provide basic patient care and coordinate diagnostic testing, indicated treatment, and specialty referral for those covered persons in the provision of eye and/or vision care benefits.
 - (B)(i) Nothing in this subchapter shall prevent a covered person from having direct access to that person's primary care provider, gatekeeper, for the treatment of eye disease or injury and being reimbursed in accordance with the terms and fee schedule of the health benefit plan.

- (ii) Further, nothing contained in this subchapter, however, shall require payment of the monthly patient management fee by the Arkansas Medicaid Program to a primary eye care provider gatekeeper;
- (5) Not discriminate between individual providers or classes of providers in the amount of reimbursement, copayment, or other financial compensation for the same or essentially similar services provided by the health benefit plan;
- (6) Not promote or recommend any individual provider or class of providers to a covered person by any method or means;
- (7) Assure that all primary eye care providers selected by persons covered by a health benefit plan are included on the list of participating providers of the plan;
- (8) Assure that an adequate number of primary eye care providers are included to guarantee reasonable accessibility, timeliness of care, convenience, and continuity of care to covered persons; and
- (9) Make available to covered persons a listing of all primary eye care providers, their practice locations, and telephone numbers on a regular, timely basis.

23-99-304. Subchapter not to prevent treatment.

Nothing in this subchapter shall prevent any person covered by a health benefit plan from receiving emergency eye care nor shall it prevent any person from exercising his or her right to receive treatment from his or her personal doctor and being reimbursed in accordance with the terms and fee schedule of the health benefit plan.

23-99-305. Remedies.

Any person adversely affected by a violation of this subchapter may bring action in a court of competent jurisdiction for injunctive relief against the health care insurer and, upon prevailing, in addition to such injunctive relief, shall recover damages not less than one thousand dollars (\$1,000) plus attorney's fees and costs.

**Subchapter 4.
Arkansas Health Care Consumer Act.**

23-99-401. Short title.

This subchapter shall be known and may be cited as the "Arkansas Health Care Consumer Act".

23-99-402. Legislative findings and intent.

As the state's insurance sector becomes increasingly dominated by managed care features that include decisions regarding coverage and appropriateness of health care, there is a vital need to protect patients in this environment.

23-99-403. Definitions.

As used in this subchapter:

- (1) "Acute condition" means a medical condition, illness, or disease having a short

- and relatively severe course;
- (2) "Commissioner" means the Insurance Commissioner of this state;
 - (3) "Covered person" means a person on whose behalf the health care insurer issuing or delivering the health benefit plan is obligated to pay benefits pursuant to the health benefit plan;
 - (4) "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 including governmental plans as defined in 29 U.S.C. § 1002(32), but excluding plans providing health care services pursuant to 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.;
 - (5) "Health care insurer" or "insurer" means any insurance company, hospital and medical services corporation, or health maintenance organization issuing or delivering health benefit plans in this state and subject to the following laws:
 - (A) The Arkansas Insurance Code, § 23-60-101 et seq.;
 - (B) Section 23-76-101 et seq., pertaining to health maintenance organizations;
 - (C) Section 23-75-101 et seq., pertaining to hospital and medical service corporations; and
 - (D) Any successor laws of the foregoing;
 - (6) "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use participating providers;
 - (7) "Participating provider" means a provider who or which 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;
 - (8) "Person" means and includes, individually and collectively, any individual, corporation, partnership, firm, trust, association, voluntary organization, or any other form of business enterprise or legal entity. "Entity" shall have the same meaning;
 - (9) "Policyholder" means the employer, union, individual, or other person or entity that purchases the health benefit plan;
 - (10) "Specialty" means a provider's particular area of specialty within his or her licensed scope of practice; and
 - (11) "Type" of provider means the licensed scope of practice.

23-99-404. Benefits for mothers and newborns.

- (a)(1) Except as provided in subsection (b) of this section, a health care insurer may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery or to less than ninety-six (96) hours following cesarean section.
- (2) A health care insurer may not require that a provider obtain authorization for prescribing any length of stay required under subdivision (a)(1) of this section.

- (b) Subdivision (a)(1) of this section shall not apply if the decision to discharge the mother or her newborn child prior to the expiration of the minimum stay is made by the attending physician in consultation with the mother.

23-99-405. Mastectomies.

- (a)(1) Every health care insurer which provides for the surgical procedure known as mastectomy may not restrict benefits for any hospital length of stay in connection with a mastectomy to less than forty-eight (48) hours, except as provided in subdivision (a)(2) of this section.
- (2) Subdivision (a)(1) of this section shall not apply in any case in which the decision to discharge the patient prior to the expiration of the minimum length of stay required in subdivision (a)(1) of this section is made by an attending physician in consultation with the patient.
- (b) Every health care insurer which provides benefits for mastectomy shall include coverage for prosthetic devices and reconstructive surgery.

23-99-406. Obstetrical and gynecological services.

- (a) In order to ensure that health care benefits are safely and appropriately delivered to women, insurers which require the selection or assignment of a primary care physician shall allow each covered person who is a woman to select a participating obstetrician/gynecologist in addition to her primary care physician.
- (b) If the woman chooses to make this selection, the insurer shall allow the woman to go directly to her selected obstetrician/gynecologist, without referral from her primary care physician, for obstetrical and gynecological services.

23-99-407. "Gag clause" prohibition.

No participating provider may be prohibited, restricted, or penalized in any way from disclosing to any covered person any health care information that the provider deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny health care services or benefits, or information on financial incentives and structures used by the insurer.

23-99-408. Continuity of care.

- (a) When health care insurers use participating providers, the insurers shall develop procedures to provide for the continuity of care of their covered persons. The procedures shall, at a minimum:
 - (1) Ensure that when a new patient is enrolled in a health benefit plan and is being treated by a nonparticipating provider for a current episode of an acute condition, the patient may continue to receive treatment as an in-network benefit from that provider until the current episode of treatment ends or until the end of ninety (90) days, whichever occurs first;
 - (2) Ensure that when a provider's participation is terminated, his or her patients under the plan may continue to receive care from that provider as an in-network benefit

until a current episode of treatment for an acute condition is completed or until the end of ninety (90) days, whichever occurs first; and

- (3) Explain how the covered person may request to continue services under subdivisions (a)(1) and (2) of this section.
- (b) During the period covered by subdivisions (a)(1) and (2) of this section, the provider shall be deemed to be a participating provider for purposes of reimbursement, utilization management, and quality of care.
- (c) Nothing in this section shall require a health care insurer to provide benefits that are not otherwise covered under the terms and provisions of the plan.

23-99-409. Prescription drug formulary.

When a health care insurer uses a formulary for prescription drugs, such insurer shall include a written procedure whereby covered persons can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the formulary when:

- (1) The formulary's equivalent has been ineffective in the treatment of the covered person's disease or condition; or
- (2) The formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the covered person.

23-99-410. Grievance procedures.

- (a) A health care insurer issuing or delivering a managed care plan shall establish for those managed care plans a grievance procedure which provides covered persons with a prompt and meaningful review on the issue of denial, in whole or in part, of a health care treatment or service.
- (b)(1) The covered person shall be provided prompt notice in writing of the outcome of the grievance procedure.
- (2) In the event the outcome is adverse to the covered person, the notice shall include specific findings related to the grievance.

23-99-411. Processing applications of providers.

- (a)(1) Health care insurers shall establish mechanisms to ensure timely processing of requests for participation or renewal by providers and in making decisions that affect participation status. These mechanisms shall include, at a minimum, provisions for the provider to receive a written statement of reasons for the health care insurer's denial of a request for initial participation or renewal.
- (2) Health care insurers shall make a decision within one hundred eighty (180) days of submission of a completed application for participation or a request for renewal.
- (b) Nothing in this section shall prevent a provider or a health care insurer from terminating a participating provider contract in accordance with its terms.

23-99-412. Provider input.

All health care insurers issuing or delivering managed care plans shall be required to establish a mechanism whereby participating providers provide input into the insurer's

medical policy, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.

23-99-413. Disclosure requirements.

Upon request, health care insurers must provide the following information in a clear and understandable form to all prospective policyholders, policyholders, and covered persons. Insurers shall notify policyholders and covered persons of their right to request the information, which must include:

- (1) Coverage provisions, benefits, and exclusions by category of service and provider;
- (2) A description of the prior authorization, precertification, and referral requirements;
- (3) The existence of prescription drug formularies and prior approval requirements for prescription drugs;
- (4) The name, number, type, specialty, and geographic location of participating providers; and
- (5)(A) Criteria by which providers are evaluated for network participation.
 - (B) Proprietary information shall not be disclosed.
 - (C) Criteria may include, but are not limited to, geographic limitations, geographic distribution of patients, specialty limitation, anticipated numbers and types of providers needed, and economic considerations. This information shall also be made available to providers upon request.

23-99-414. Regulations.

The Insurance Commissioner may promulgate necessary rules and regulations for carrying out this subchapter.

23-99-415. Enforcement and penalties.

The Insurance Commissioner shall have all the powers to enforce this subchapter as are granted to the commissioner elsewhere in the Arkansas Insurance Code, § 23-60-101 et seq.

23-99-416. Application of subchapter.

This subchapter applies to all health benefit plans issued, renewed, extended, or modified on or after August 1, 1997. "Renewed, extended, or modified" shall include all health benefit plans in which the insurer has reserved the right to change the premium.

**Subchapter 5.
Arkansas Mental Health Parity Act.**

23-99-501. Short title.

This subchapter shall be known and may be cited as the "Arkansas Mental Health Parity Act".

23-99-502. Legislative findings and intent.

It is the intent of this state that insurance coverage for mental illnesses and the mental health treatment of those with developmental disorders shall be as available and at parity with that for other medical illnesses.

23-99-503. Definitions.

As used in this subchapter:

- (1) "Carve-out arrangement" means an arrangement in which a health care insurer contracts with a separate person or entity to arrange for the delivery of specific types of health care benefits under a health benefit plan;
- (2) "Commissioner" means the Insurance Commissioner of the State of Arkansas;
- (3) "Financial requirements" means copayments, deductibles, out-of-network charges, out-of-pocket contributions or fees, annual limits, lifetime aggregate limits imposed on individual patients, and other patient cost-sharing amounts;
- (4) "Health benefit plan" means any group or blanket plan, policy or contract for health care services issued or delivered in this state by health care insurers, including indemnity and managed care plans, but excluding plans providing health care services to state employees or pursuant to 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.;
- (5) "Health care insurer" means any insurance company, hospital and medical services corporation, or health maintenance organization issuing or delivering health benefit plans in this state and subject to any the following laws:
 - (A) The Arkansas Insurance Code, § 23-60-101 et seq.;
 - (B) Section 23-75-101 et seq., pertaining to hospital and medical service corporations;
 - (C) Section 23-76-101 et seq., pertaining to health maintenance organizations; and
 - (D) Any successor law of the foregoing;
- (6) "Mental illnesses" and "developmental disorders" mean those illnesses and disorders listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders;
- (7) "Person" or "entity" means and includes, individually and collectively, any individual, corporation, partnership, firm, trust, association, voluntary organization, or any other form of business enterprise or legal entity; and
- (8) "Small employer" means any person or entity actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no more than fifty (50) eligible employees.

23-99-504. Exclusions.

This subchapter shall not apply to:

- (1) Dental insurance plans;
- (2) Vision insurance plans;

- (3) Specified-disease insurance plans;
- (4) Accidental injury insurance plans;
- (5) Long-term care plans;
- (6) Disability income plans;
- (7) Individual health benefit plans, provided that health care insurers shall offer individuals the option of purchasing a plan that, other than being optional, meets all the other requirements of this subchapter;
- (8) Health benefit plans for small employers, provided that health care insurers shall offer purchasers the option of purchasing a plan that, other than being optional, meets all the other requirements of this subchapter; and
- (9) Medicare supplement plans, as subject to section 1882(g)(1) of the federal Social Security Act, 42 U.S.C. § 1395ss.

23-99-505. Increased cost exemption.

- (a) This subchapter shall not apply with respect to a health benefit plan if the application of this subchapter to the plan will result in an increase in the cost under the plan of at least one and one-half percent (1.5%).
- (b) The Insurance Commissioner shall develop regulations to implement this exemption and, in doing so, may look for guidance in the regulations promulgated by the federal Department of Health and Human Services in implementing the federal Mental Health Parity Act, Pub.L. 104-204, section 712(c)(2).

23-99-506. Parity requirements.

- (a) Except as provided in § 23-99-504, every health benefit plan shall provide medical coverage for the diagnosis and mental health treatment of mental illnesses and the mental health treatment of those with developmental disorders.
- (b) A health benefit plan shall provide benefits for diagnosis and mental health treatment of mental illnesses and developmental disorders under the same terms and conditions as provided for covered benefits offered under the health benefit plan for the treatment of other medical illnesses or conditions. There shall be no differences in the health benefit plan in regard to any of the following:
 - (1) The duration or frequency of coverage;
 - (2) The dollar amount of coverage; or
 - (3) Financial requirements.
- (c) Nothing in this subchapter shall be construed:
 - (1) As requiring equal coverage between treatments for a mental illness or a developmental disorder with coverage for preventive care;
 - (2) As prohibiting a health care insurer from:
 - (A) Negotiating separate reimbursement rates and service delivery systems, including, but not limited to, a carve-out arrangement;
 - (B) Managing the provision of mental health benefits for mental illnesses and the mental health treatment of those with developmental disorders by common methods used for other medical conditions, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms

designed to limit coverage of services for mental illnesses and developmental disorders to those that are deemed medically necessary;

- (C) Limiting covered services to those authorized by the health insurance policy, provided that such limitations are made in accordance with this subchapter;
 - (D) Using separate but equal cost-sharing features for mental illnesses or developmental disorders as for other medical illness; or
 - (E) Using a single lifetime or annual dollar limit as applicable to other medical illness; and
- (3) As including a medicare or medicaid plan or contract or any privatized risk or demonstration program for medicare or medicaid coverage.

23-99-507. Medical necessity.

- (a) This subchapter shall not be construed as prohibiting a health benefit plan from excluding coverage for diagnosis and treatment of mental illnesses and developmental disorders when the diagnosis and treatment are medically unnecessary, provided that the medical necessity determination is made in accordance with generally accepted standards of the medical profession and other applicable laws and regulations.
- (b) The term "medical necessity" as applied to benefits for mental illnesses and developmental disorders means:
 - (1) Reasonable and necessary for the diagnosis or treatment of a mental illness, or to improve or to maintain or to prevent deterioration of functioning resulting from the illness or developmental disorder;
 - (2) Furnished in the most appropriate and least restrictive setting in which services can be safely provided;
 - (3) The most appropriate level or supply of service which can safely be provided; and
 - (4) Could not have been omitted without adversely affecting the individual's mental or physical health, or both, or the quality of care rendered.

23-99-508. Permitted provisions.

- (a) A health care insurer may at the insurer's option provide coverage for a health service, such as intensive case management, community residential treatment programs, or social rehabilitation programs, which is used in the treatment of mental illnesses or developmental disorders, but is generally not used for other injuries, illnesses, and conditions, as long as the other requirements of this subchapter are met.
- (b) Health care insurers providing chemical dependency treatment or educational remediation may, but are not required to, comply with the terms of this subchapter in regard to the treatment or remediation.
- (c) A health care insurer may provide coverage for a health service, including, but not limited to, physical rehabilitation or durable medical equipment, which generally is not used in the diagnosis or treatment of serious mental illnesses, but is used for other injuries, illnesses, and conditions, as long as the other requirements of this subchapter are met.

23-99-509. Applicability.

- (a) On or after August 1, 1997, this subchapter shall apply to health benefit plans on the plans' anniversaries or start dates, but in no event later than one (1) year after August 1, 1997.
- (b) If a health benefit plan provides coverage or benefits to an Arkansas resident, the plan shall be deemed to be delivered in this state within the meaning of this subchapter, regardless of whether the health care insurer or other entity that provides the coverage is located within or outside of Arkansas.

23-99-510. Regulations.

The Insurance Commissioner shall enforce this subchapter and shall promulgate necessary rules and regulations for carrying out this subchapter.

23-99-511. Enforcement.

The Insurance Commissioner shall have all the powers to enforce this subchapter as are granted to the commissioner elsewhere in the Arkansas Insurance Code, § 23-60-101 et seq.

**Subchapter 6.
Dental Point of Service Option.**

23-99-601. Short title.

This subchapter shall be cited as the "Dental Point of Service Act".

23-99-602. Legislative findings.

The General Assembly finds that the quality of dental care is improved through patient choice among dentists and that utilization of dentists varies less than utilization of other providers. Patients should have the freedom to go to dentists outside their managed care network when the carrier is not required to pay the dentist more than it pays in-network dentists. Therefore, health carriers should be required to offer a point-of-service option for dental care.

23-99-603. Definitions.

As used in this subchapter:

- (1) "Commissioner" means the Insurance Commissioner;
- (2) "Covered person" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan;
- (3) "Dentist" means a person licensed under the Arkansas Dental Practice Act, § 17-82-101 et seq.;
- (4) "Health care service" means that service offered or provided by the health care providers within the scope of their practice and relating to the prevention, cure, or treatment of illness or disease;
- (5) "Health carrier" means any insurance company, health maintenance organization, or hospital and medical service corporation as defined in § 23-75-101, subject to

the following laws:

- (A) The Arkansas Insurance Code, § 23-60-101 et seq.;
 - (B) Provisions pertaining to health maintenance organizations, § 23-76-101 et seq.; and
 - (C) Any successor laws of the foregoing; and
- (6) "Health plan" means any policy, contract, or agreement offered by a health carrier to provide, reimburse, or pay for health care services except the following:
- (A) Workers' compensation coverage;
 - (B) Self-funded or self-insured health plans, unless the plan is established or maintained for employees of a governmental entity; and
 - (C) A policy, contract, or agreement that limits coverage for dental services in connection with the treatment of a covered accidental injury or the treatment of a nondental physiological condition.

23-99-604. Coverage for out-of-network dentists.

- (a) Every health plan which provides dental benefits issued, renewed, extended, or modified by a health carrier shall also include a point-of-service option which provides benefits to covered persons through dentists who are not members of the carrier's provider network.
- (b)(1) The benefits offered under this option shall be the same as those offered through the network.
 - (2) The rate of reimbursement for out-of-network dentists may differ from the rate of reimbursement for noncapitated dentists in the network, but by no more than ten percent (10%).
 - (3) The copayment, coinsurance, and other cost-sharing features may differ between the use of in-network and out-of-network dentists, but by no more than twenty-five percent (25%).
- (c) The out-of-network dentist may bill the patient for the balance of any charges which are not otherwise reimbursed by the health carrier. If, however, after a request by the covered person in advance of treatment, the provider fails to disclose a reasonable range of the total of charges for nonemergency services to be provided, the covered person shall not be liable for such additional charges.
- (d) The health carrier shall fully disclose to the covered person, in clear, understandable language, the terms and conditions of this option. This requirement may be satisfied by the health carrier's providing to the employer or other purchaser of the plan presentation materials for dissemination to covered persons.

23-99-605. Rules and regulations.

Within one hundred twenty (120) days of July 30, 1999, the Insurance Commissioner shall promulgate necessary rules and regulations for carrying out this subchapter, giving maximum possible effect to the General Assembly's intent to promote quality medical care through increased choice.

23-99-606. Insurance Commissioner's enforcement authority.

The Insurance Commissioner shall enforce this subchapter, using the powers granted to the commissioner elsewhere in the Arkansas Insurance Code, § 23-60-101 et seq.

23-99-607. Duty of Attorney General to defend.

In any legal proceeding in which the validity of this subchapter is challenged, the Attorney General shall defend the subchapter regardless of the state agency or official named as an official party.

23-99-608. Applicability of subchapter.

This subchapter applies to health plans issued, renewed, extended, or modified by a health carrier on or after July 30, 1999. "Renewed, extended, or modified" shall include a change in premium or other financial term.

Subchapter 7.

Grievance Systems and Quality Assessment and Improvement Systems.

23-99-701. Legislative findings.

The General Assembly finds and declares the following:

- (1) The State of Arkansas has an interest in protecting its citizens and in pursuing reasonable means to improve the quality of life and health of those citizens;
- (2) In the health care field, the State of Arkansas has traditionally regulated utilization review as well as the quality of care provided by health care providers, insurance companies, and organizations which assume the risk of providing health care services for citizens of this state, such as health maintenance organizations; and
- (3) Dynamic changes in how health care is delivered to citizens of this state require the state to oversee the quality of health care processes and outcomes resulting from health carriers and networks.

23-99-702. Definitions.

For the purpose of this subchapter:

- (1) "Commissioner" means the Insurance Commissioner;
- (2) "Director" means the Director of the Department of Health;
- (3) "Health care services" means any services included in the furnishing to any individual of medical or dental care, hospitalization, or services incident to the furnishing of care or hospitalization, as well as the furnishing to any person of any and all other services or goods for the purpose of preventing, alleviating, curing, or healing human illness or injury;
- (4) "Health carrier" means any person who undertakes to provide or arrange for one (1) or more managed care plans;
- (5) "Managed care plan" means any arrangement whereby a health carrier undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services, and at least part of the arrangement consists of arranging for or the provision of health care services as distinguished from mere indemnifications

against the cost of the services on a prepaid basis through insurance or otherwise;
and

- (6) "Network" when used to describe a provider of health services, including, but not limited to, a hospital, physician, home health agency, pharmacy, etc., means the provider has a participation agreement in effect with a health carrier, directly or through another entity, to provide health services to covered persons.

23-99-703. Grievance system.

- (a) All health carriers and networks shall make arrangements for handling and resolving grievances.
- (b) Each health carrier and network shall:
 - (1) Maintain records of grievances filed with such health carrier and network concerning the quality of health care services; and
 - (2) Submit in the form and manner prescribed by the Director of the Department of Health a periodic report which shall include:
 - (A) A written description of the processes and procedures for resolving grievances; and
 - (B) The total number of grievances handled through such grievance system, including a compilation of the dates of the grievances, the reason for the grievances, and resolutions of each grievance.
- (c) In consultation with the Insurance Commissioner, the director may promulgate rules and regulations in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., to carry out the provisions of this subchapter to enable the state to be properly informed of quality issues within the state and to adequately respond to any quality concerns expressed through grievances.

23-99-704. Quality assessment and improvement systems.

- (a) Each health carrier and network shall:
 - (1) Make arrangements for measuring and improving the quality of health care services;
 - (2) Maintain quality assessment and improvement programs and records measuring the outcomes of health care services; and
 - (3) Submit to the Director of the Department of Health in the time, manner, and form prescribed the following information:
 - (A) A written description of any quality assessment and quality improvement systems; and
 - (B) Findings of relevant quality data as determined by the director.
- (b) In consultation with the Insurance Commissioner, the director may promulgate rules and regulations in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., to carry out the provisions of this subchapter to enable the state to be properly informed of quality issues within the state and to adequately respond to any quality concerns found through the outcome data.
- (c) The provisions of §§ 16-46-105 and 20-9-501 et seq. shall apply to all records maintained pursuant to this subchapter.

23-99-705. Applicability and scope.

- (a) This subchapter shall not apply to disability income, specified disease, medicare supplement, hospital indemnity, accident-only policies, long-term care, short-term limited duration insurance, and all other supplemental insurance products issued by health carriers.
- (b) In terms of the Director of the Department of Health's regulatory authority pursuant to §§ 23-99-703 and 23-99-704, such authority shall apply to the quality of care provided by health carriers and networks operating in this state and shall not apply to the benefits offered by any health carrier and network or to the administration of such benefits.

23-99-706. Enforcement and penalties.

The Director of the Department of Health shall have the power to implement and enforce this subchapter.