Arkansas Insurance Department

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DIRECTIVE: 2-2005

TO: ALL HEALTH MAINTENANCE ORGANIZATIONS, ACCIDENT AND HEALTH INSURANCE COMPANIES, ACCIDENT AND HEALTH INSURANCE AGENTS, THE ARKANSAS MEDICAL SOCIETY, THE ARKANSAS HOSPITAL ASSOCIATION, AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: ARKANSAS' "ANY WILLING PROVIDER" LAWS

DATE: JULY 15, 2005

The Department issues this Directive to advise all health maintenance organizations ("HMOs") and accident and health insurers conducting business in this state about compliance with Arkansas' Patient Protection Act of 1995 and recent "Any Willing Provider" ("AWP") legislation passed by the Arkansas State Legislature in 2005, in light of a recent decision by the 8th Circuit Court of Appeals ("8th Circuit") on June 29, 2005 in Prudential Insurance Co., et al. v. HMO Partners, Inc., et al., U.S.C.A. No. 04-1465/04-1644 ("Prudential II"). This decision will ultimately apply Arkansas' 1995 AWP Law to insured ERISA ("Employee Retirement Income Security Act") plans and non-ERISA health plans.

In 1995, the Arkansas State Legislature ("Legislature") enacted Acts 505 ("To Ensure Consumer Choice of Health Care Provider") and 1193 ("An Act To Assure The Gatekeeper System Is Preserved And Existing Contracts Are Not Impaired Under The Provisions Of The Patient Protection Act Of 1995"). These two Acts combined are the "The Patient Protection Act of 1995" ("1995 PPA") that required a health care insurer to accept a medical provider in the health insurer's medical network, if the provider agreed to the insurer's terms and conditions. However, before the 1995 PPA became effective, various parties successfully brought suit to prevent the Act's enforcement. Since its inception, the 1995 PPA has been before the courts and has never been enforced.

In 2005, the Legislature passed several new AWP statutes. Act 490 ("Patient Protection Act of 2005") provided a new AWP law designed to become effective only if the courts ultimately held the 1995 PPA invalid and preempted by ERISA in its entirety. Because the Eighth Circuit recently upheld the 1995 PPA, the 1995 PPA is the law, and Act 490 will not go into effect.

It is the Department's opinion that the remaining AWP legislation passed in the 2005 Legislative Session as Act 491 ("An Act To Provide For Enforcement Of The Patient Protection Act of 2005") and Act 960 ("An Act To Amend The Private Enforcement Provisions Of The Patient

Protection Act Of 1995 And The Patient Protection Act Of 2005") will become effective on August 12, 2005. The Department advises all HMO and accident and health insurers (as defined in Section 5(5) of Act 491 of 2005) to review and be expected to comply with the 1995 PPA, codified in Ark. Code Ann. §23-99-201, *et. seq.*, as amended by Acts 491 and 960 of 2005.

Health Benefit Plans Subject To The 1995 PPA As Amended This Legislative Session

In Prudential II, the 8th Circuit explained that the 1995 PPA was a state law saved from preemption by ERISA to the extent that the law "regulated insurance" and was aimed at "entities engaged in insurance" or the "insurance industry." The Court concluded that AWP applied to "non-ERISA health plans" and "insured ERISA plans." However, because "self-funded" ERISA health plans were not "insured," AWP was preempted to the extent it applied to a self-funded ERISA health plan. The Department therefore advises that it intends to apply AWP to all fully-insured health benefit plans: insured by group and individual accident and health policies, health maintenance organization contracts, hospital and medical service contracts, and any other "health benefit plan" defined in Act 491 of 2005.

Generally, health benefit plans that are not subject to AWP include *self-funded* employer plans, even if the health plan hires an insurance company to administer plan benefits or pays for access to a health insurer's provider network.

After reviewing the decision in Prudential II and the 1995 PPA, as amended by Acts 491 and 960 of 2005, the Department describes types of group health benefit plans most common in Arkansas to further clarify the application of AWP to health benefit plans:

1. Insured ERISA plans. These health benefit plans are fully subject to the 1995 PPA, as amended, and provider networks used by them must be AWP-compliant. This is true even if a "non-insurer" (as defined in Section 5(6) of Act 491) provides the plan with a network of medical providers. In other words, with regard to insured plans, the ultimate responsibility for compliance with AWP rests with the health insurer. [Act 491, Section 4(d)(4)].

2. Self-funded ERISA plans. Prudential II holds that self-funded ERISA plans are AWP-exempt, and that the 1995 PPA, as amended, cannot be used to directly or indirectly regulate the operations of self-funded ERISA plans.

3. Self-funded *non*-ERISA health benefit programs. There exist group health benefit plans which are not subject to the ERISA statutory regime, including but not limited to governmental health benefit plans and church plans. These *non*-ERISA plans are subject to the 1995 PPA unless (1) they are self-funded and (2) contract directly with a "non-insurer" (such as a typical Physician Hospital Organization, Independent Practice Association, or third-party administrator) to provide the plan with a network of medical providers, under Section 4(d)(1) and (2) of Act 491 of 2005. Please note however that if a non-ERISA plan, whether self-funded or insured, arranges with a health insurer to provide the plan with a network of medical providers, the plan is

subject to the 1995 PPA as amended. Again, this paragraph applies in the unique circumstances of *non*-ERISA plans. Most group plans, whether self-funded or insured, are ERISA plans.

4. Arkansas State Employees Health Benefit Plan. It is the Department's position that because the state employee's health plan is a self-funded *non*-ERISA health plan that has not contracted with a "non-insurer" for a provider network, the health plan is subject to AWP. It is the Department's position that any self-funded governmental or church health benefit plan which has contracted with an insurer to provide the plan with a network of medical providers is a non-ERISA plan subject to AWP, for the reasons explained in paragraph 3. Any insured *non*-ERISA plan is subject to AWP.

5. Workers' Compensation Health Benefits. After researching the historical definition of a "health benefit plan" in the 1995 PPA, which excepted AWP from applying to workers compensation benefits, and researching the legislative intent behind recent changes to the definition of "health benefit plan," the Department's position is that AWP was not intended to apply to workers' compensation health benefits. Workers' Compensation was excluded from application of AWP in 1995, and the structure and nature of the medical compensation itself derives from liability insurance, rather than health insurance.

Health Care Providers Entitled To Any Willing Provider Rights

Medical providers entitled to request AWP access are listed in Act 491 of 2005. AWP access is not restricted to licensed physicians. Other providers are entitled to request AWP access, and these include podiatrists, chiropractors, physical therapists, speech pathologists, audiologists, dentists, optometrists, hospitals, psychologists, licensed professional counselors, respiratory therapists, pharmacists, occupational therapists, long-term care facilities, home health care providers, hospice care providers, licensed ambulatory surgery centers, rural health clinics, licensed certified social workers, licensed psychological examiners, advanced practice nurses, licensed dieticians, community mental health centers or clinics, certified orthotists, prosthetists, licensed durable medical equipment providers, and other medical providers determined by regulations of the Insurance Department. At this time, the Department has not promulgated any rule expanding or modifying the list of medical providers entitled to request AWP access. There is no requirement in the AWP laws to provide coverage of any particular health care service. If the service of a particular class of providers (e.g., chiropractors, dieticians, hospice, etc.) is included in the health benefit plan, then all providers in that same class who qualify for membership are eligible to be part of the plan's network. (Ark. Code Ann. §§ 23-99-204(b) and 205; Act 491, Section 4(c)(1)).

The Department advises health care insurers to pay particular attention to the fact that hospital services are included in AWP in the definition of "health care provider" in Act 491 of 2005; therefore, hospitals that agree to the terms and conditions of the health care plan are entitled to AWP access and rights with health care insurers.

Health Care Provider Requests For Network Access

AWP does not describe the mechanics and timing of health care provider requests for network access with the health care insurer. Providers interested in being admitted into a network should contact the insurer or HMO for an application. The Department advises every HMO and accident and health insurer to promptly give providers a written application and a description in writing of the application process for each medical provider requesting network access with the health care insurer. In addition, the health care insurer should provide a written description of the health care insurer's terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards. Ark. Code Ann. §23-99-204(3). Act 491 of 2005 requires that the health care insurer "apply such terms and conditions in a nondiscriminatory manner." The Department advises that every health care insurer should follow Ark. Code Ann. §23-99-411 and take no longer than 180 days to process completed applications from medical providers.

Restriction On Health Care Provider Discrimination

Arkansas law prohibits health care insurers from imposing any monetary advantage, penalty, or higher copayment under a health benefit plan that would affect a beneficiary's choice of health care providers. Health care insurers should abide by the "non-discrimination" requirements on health care providers in Ark. Code Ann. §23-99-204. AWP prohibits the imposition upon a beneficiary of a health care service any copayment, fee or condition that is not equally imposed on all beneficiaries in the same benefit category, class, or copayment level when the beneficiary is receiving services from a participating health care provider under the health benefit plan. However, the law does not prohibit varying the level of co-payment, fee or condition as between provider types. Also, it is the Department's position that the above requirements only apply to health care providers who have agreed to the terms and conditions of the health benefit plan in Ark. Code Ann. §23-99-204(a)(3).

For questions regarding this Directive, please contact the Legal Division of the Arkansas Insurance Department, 501-371-2820.

(Signed by Julie Benafield Bowman) (July 15, 2005)

JULIE BENAFIELD BOWMAN DATE
INSURANCE COMMISSIONER
STATE OF ARKANSAS