State of Arkansas *As Engrossed: H2/20/25*
95th General Assembly **A Bill**
Regular Session, 2025 HOUSE BILL 1299

By: Representative L. Johnson
By: Senator Irvin

For An Act To Be Entitled

AN ACT TO PROHIBIT HEALTHCARE INSURERS FROM EXERCISING RECOUPMENT FOR PAYMENT OF HEALTHCARE SERVICES MORE THAN ONE YEAR AFTER PAYMENT FOR HEALTHCARE SERVICES WAS MADE; AND FOR OTHER PURPOSES.

Subtitle

TO PROHIBIT HEALTHCARE INSURERS FROM EXERCISING RECOUPMENT FOR PAYMENT OF HEALTHCARE SERVICES MORE THAN ONE YEAR AFTER THE PAYMENT FOR HEALTHCARE SERVICES WAS MADE.

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

SECTION 1. Arkansas Code Title 23, Chapter 99, is amended to add an additional subchapter to read as follows:

Subchapter 19 — Recoupment

23-99-1901. Definitions.

As used in this subchapter:

(1) "Abuse" means provider practices that:

(A) Are inconsistent with sound fiscal, business, or medical practices; and

(B) Result in unnecessary cost or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care;

(2) "Covered person" means an individual who is entitled to receive healthcare services under the terms of a health benefit plan;

(3)(A) "Fraud" means a purposeful deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or another person.

(B) "Fraud" includes an act that constitutes fraud under applicable federal or state law;

(4)(A) "Health benefit plan" means an individual, blanket, or 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 and 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 plan that provides only dental benefits or eye and vision care benefits;

(ii) A disability income plan;

(iii) A credit insurance plan;

(iv) Insurance coverage issued as a supplement to liability insurance;

(v) Medical payments under an automobile or homeowners insurance plan;

(vi) A health benefit plan provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(vii) A plan that provides only indemnity for hospital confinement;

(viii) An accident-only plan;

(ix) A specified disease plan; or

(x) A plan provided under the Medicaid Provider-Led Organized Care Act, § 20-77-2701;

(5)(A) "Healthcare insurer" means an entity that is subject to state insurance regulation and provides coverage for health benefits in this

state.

(B) "Healthcare insurer" includes:

(i) An insurance company;

(ii) A health maintenance organization;

(iii) A hospital and medical service corporation; and

(iv) A sponsor of a nonfederal self-funded governmental healthcare plan;

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

(7) "Recoupment" means an action or attempt by a healthcare insurer to recover or collect payments already made to a healthcare provider with respect to a claim by:

(A) Reducing other payments currently owed to the healthcare provider;

(B) Withholding or setting off the amount against current or future payments to the healthcare provider;

(C) Demanding repayment from a healthcare provider for a claim already paid; or

(D) Any other means that reduce or affect the future claim *payments to the healthcare provider; and*

(8) "Waste" means the overuse of services or practices that directly or indirectly result in unnecessary cost to a health benefit plan.

23-99-1902. Time.

(a) Except in cases of *fraud, waste, or abuse committed* by a healthcare provider, a healthcare insurer may exercise recoupment from a healthcare provider only within three hundred sixty-five (365) days after the date that the healthcare insurer paid the claim submitted by the healthcare provider.

(b)(1) A healthcare insurer that exercises recoupment under subsection (a) of this section shall give the healthcare provider a written or electronic statement specifying the basis for the recoupment.

(2) The statement required under subdivision (b)(1) of this section shall include:

(A) The disclosure information required under § 23-99-1904; and

(B)(i) Notice of any right to internal appeal by the healthcare provider.

(ii) If the healthcare provider initiates an internal appeal under subdivision (b)(2)(B)(i) of this section, the healthcare insurer shall suspend recoupment efforts for the alleged overpayment until such time as the healthcare insurer has prevailed after the healthcare provider has exhausted all available internal appeals.

23-99-1903. Persons not covered.

(a) Except in the case of *fraud, waste, or abuse committed* by a healthcare provider or as described under subdivision (b)(1) of this section, a healthcare insurer shall not exercise recoupment if:

(1) The healthcare provider or other party on its behalf *verified the patient eligibility for a covered service from the healthcare insurer or its agent; and*

(2) The healthcare provider provided healthcare services to the covered person in good-faith reliance on the verification.

(b)(1) A healthcare insurer has ninety (90) days from the date of *services to* notify the healthcare provider of a verification error and the fact that healthcare services rendered will not be covered if:

(A) The verification error was made in good-faith reliance at the time of the verification upon information provided by the party responsible for enrolling a covered person in the health benefit plan; and

(B) The party responsible for enrolling a covered person in the health benefit plan is separate and independent from, and is not an employee, representative, assignee, affiliate, subsidiary, or otherwise under the common control of, the healthcare insurer.

(2) If a recoupment notice is sent based upon a verification error under subdivision (b)(1) of this section, the healthcare insurer shall include a specific explanation of the error.

23-99-1904. Disclosure required — Exercising recoupment.

(a) A healthcare insurer shall give written notice to a healthcare provider of the healthcare insurer's intent to exercise recoupment if the

healthcare insurer determines that payment was made:

(1) For healthcare services not covered under the covered person's health benefit plan; or

(2) To a person who was ineligible to receive benefits under the health benefit plan.

(b) A healthcare insurer may:

(1) Request a refund from a healthcare provider; or

(2) Exercise recoupment of the payment from the healthcare provider under this section.

(c) If a healthcare insurer exercises recoupment, then the healthcare insurer shall provide the healthcare provider written documentation that specifies the:

(1) Amount of the recoupment;

(2) Covered person's name to which the recoupment applies;

(3) Patient identification number;

(4) Date of the healthcare service;

(5) Healthcare service on which the recoupment is based;

(6) Pending claim being recouped or future claim that is anticipated to be recouped; and

(7) Specific reason for the recoupment.

(d)(1) In a recoupment based upon medical necessity determinations, level of service determinations, coding errors, or billing irregularities, the healthcare insurer exercising recoupment shall ensure that the recoupment is reconciled to specific claims and shall provide specific reasons for the recoupment.

(2) A specific reason for recoupment under subdivision (d)(1) of this section shall not consist of mere conclusionary statements but shall contain specific information from which the healthcare provider can determine the basis for the recoupment and make a reasoned determination about whether to challenge the recoupment.

(3) If the healthcare provider obtained prior authorization for the healthcare service for the covered person from the healthcare insurer or the healthcare insurer's employee, agent, representative, or assign, the healthcare insurer shall not exercise recoupment based upon a retroactive medical necessity determination or level of service determination except in instances of *fraud, waste, or abuse by* the healthcare provider in obtaining

the prior authorization.

(e)(1) If a prior authorization is not obtained by the healthcare provider and the healthcare insurer exercises recoupment based on a determination that the healthcare provider billed the wrong level of care, the healthcare insurer shall state in the notice of recoupment which level of care the healthcare insurer has determined would have been appropriate.

(2) If a prior authorization is not obtained by a healthcare provider and the healthcare insurer exercises recoupment based on a determination that the healthcare service rendered was not medically necessary, the healthcare insurer shall include with the notice of recoupment:

(A) The specific criteria required for medical necessity for the healthcare service; and

(B) The specific reason why the respective healthcare service failed to meet the criteria described under subdivision (e)(2)(A) of *this section.*

(3) Upon notice being served under subdivision (e)(1) or subdivision (e)(2) of this section, a healthcare provider shall have ninety (90) days to correct the claim and resubmit the claim regardless of a timely filing provision under a contract or policy or procedure restrictions.

23-99-1905. Unfair trade practices.

A healthcare insurer that fails to comply with this subchapter is subject to and in violation of the Trade Practices Act, § 23-66-201 et seq.

/s/L. Johnson