State of Arkansas *As Engrossed: H2/15/23 H2/28/23*
94th General Assembly **A Bill**
Regular Session, 2023 HOUSE BILL 1121

By: Representatives F. Allen, *K. Brown, Dalby, Evans, K. Ferguson, L. Johnson, Nicks, Pilkington, J. Richardson, Warren*
By: Senators D. Wallace, J. Boyd, Irvin, M. Johnson, R. Murdock

For An Act To Be Entitled

AN ACT CONCERNING COVERAGE FOR BIOMARKER TESTING FOR EARLY DETECTION AND MANAGEMENT FOR CANCER DIAGNOSES; AND FOR OTHER PURPOSES.

Subtitle

CONCERNING COVERAGE FOR BIOMARKER TESTING FOR EARLY DETECTION AND MANAGEMENT FOR CANCER DIAGNOSES.

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

SECTION 1. Arkansas Code Title 23, Chapter 79, is amended to add an additional subchapter to read as follows:

Subchapter 24 — Coverage for Biomarker Testing for Early Detection and Management for Cancer Diagnoses

23-79-2401. Definitions.

As used in this subchapter:

(1)(A) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic *intervention, including known gene-drug interactions for medications being considered for use or already being administered.*

(B) "Biomarker" includes without limitation gene mutations

or protein expression;

(2)(A) "Biomarker testing" means the analysis of a patient's tissue, blood, *or other biospecimen* for the presences of a biomarker.

(B) "Biomarker testing" includes without limitation *single-analyte tests, multiplex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing;*

(3) "Consensus statement" means a statement that:

(A) Is developed by an independent, multidisciplinary panel of experts that uses a transparent methodology and reporting structure that includes a conflict of interest policy;

(B) Is based on the best available evidence for the purpose of optimizing clinical care outcomes; and

(C) Is aimed at specific clinical circumstances;

(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 indemnity and managed care plans.

(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., and 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;

(x) The Arkansas Medicaid Program; or

(xi) A program established by the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.;

(5)(A) "Healthcare insurer" means any insurance company, hospital and medical service corporation, or health maintenance organization that issues or delivers health benefit plans in this state and is subject to any of the following laws:

(i) The insurance laws of this state;

(ii) Section 23-75-101 et seq., pertaining to hospital and medical service corporations; or

(iii) Section 23-76-101 et seq., pertaining to health maintenance organizations.

(B) "Healthcare insurer" does not include an entity that provides only dental benefits or eye and vision care benefits;

(6) "Healthcare professional" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer *health care in the ordinary course of the practice of his or her profession;*

(7) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that:

(A) Are developed by independent organizations or medical professional societies using a:

(i) Transparent methodology and reporting structure; and

(ii) Conflict of interest policy; and

(B) Establish standards of care that are informed by:

(i) A systemic review of evidence; and

(ii) An assessment of the benefits and costs of alternative care options that includes recommendations intended to optimize patient care;

(8)(A) "Subscriber" means an individual eligible to receive coverage of healthcare services by a healthcare professional under a health benefit plan.

(B) "Subscriber" includes a subscriber's legally authorized representative;

(8) "Urgent healthcare service" means a healthcare service for a non-life-threatening condition that, in the opinion of a physician with

knowledge of a subscriber's medical condition, requires prompt medical care in order to prevent:

(A) A serious threat to life, limb, or eyesight;

(B) Worsening impairment of a bodily function that threatens the body's ability to regain maximum function;

(C) Worsening dysfunction or damage of any bodily organ or part that threatens the body's ability to recover from the dysfunction or damage; or

(D) Severe pain that cannot be managed without prompt medical care; and

(10)(A) "Utilization review entity" means an individual or entity that performs prior authorization for at least one (1) of the following:

(i) A healthcare insurer;

(ii) A preferred provider organization or health maintenance organization; or

(iii) Any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a healthcare provider in this state under a policy, health benefit plan, or contract.

(B) A healthcare insurer is a utilization review entity if the healthcare insurer performs prior authorization.

(C) "Utilization review entity" does not include an insurer of automobile, homeowners, or casualty and commercial liability insurance or the insurer's employees, agents, or contractors.

23-79-2402. Coverage for biomarker testing for early detection and management for cancer diagnoses.

(a) A health benefit plan that is offered, issued, or renewed in this *state shall provide coverage for biomarker testing.*

(b) The evidence of coverage document provided with a health benefit plan under this subchapter shall include biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a subscriber's disease or condition to guide treatment decisions when the biomarker test is supported by medical and scientific evidence, including without limitation:

(1) Labeled indications for tests that are approved or cleared by the United States Food and Drug Administration;

(2) Indicated tests for a drug that is approved by the United States Food and Drug Administration;

(3) Warnings and precautions on United States Food and Drug Administration-approved drug labels;

(4) Centers for Medicare & Medicaid Services national coverage determinations or Medicare administrative contractor local coverage determinations; or

(5) Nationally recognized clinical practice guidelines and consensus statements.

(c) A health benefit plan shall ensure that coverage is provided in a manner that limits disruptions in care, including the need for multiple biopsies and biospecimen samples as determined by a healthcare professional.

(d)(1) A subscriber and a subscriber's healthcare professional shall have access to a clear, readily available, and convenient process to request an exception to a health benefit plan under this subchapter.

(2) The process under subdivision (d)(1) of this section shall be readily accessible on the health benefit plan's website.

(3) This section shall not be construed to require a separate process if the health benefit plan's existing process complies with subdivision (d)(1) of this section.

(e) A utilization review entity shall make a determination on a request for coverage of biomarker testing at the same scope, duration, and frequency as the health benefit plan otherwise provides to subscribers.

(f) If prior authorization is required for biomarker testing, the utilization review entity shall approve or deny a prior authorization request and notify the subscriber, the subscriber's healthcare professional, and any entity requesting prior authorization of the healthcare service:

(1) Within seventy-two (72) hours for request for nonurgent healthcare services; or

(2) Within twenty-four (24) hours for requests for urgent healthcare services.

APPROVED: 4/4/23