State of Arkansas *As Engrossed: S3/15/11 S3/22/11*
88th General Assembly A Bill
Regular Session, 2011 SENATE BILL 839

By: Senator Irvin

For An Act To Be Entitled

AN ACT TO PROTECT PATIENTS BY ENSURING THAT PRIOR AUTHORIZATION PROCEDURES DO NOT INTRUDE ON THE PHYSICIAN-PATIENT RELATIONSHIP OR PUT COST SAVINGS AHEAD OF OPTIMAL PATIENT CARE; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO PROTECT PATIENTS BY ENSURING THAT PRIOR AUTHORIZATION PROCEDURES DO NOT INTRUDE ON THE PHYSICIAN-PATIENT RELATIONSHIP OR PUT COST SAVINGS AHEAD OF OPTIMAL PATIENT CARE.

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

SECTION 1. Arkansas Code Title 23, Chapter 99, Subchapter 4 is amended to add an additional section to read as follows:

20-99-418. Prior authorization.

(b) As used in this section:

(1) "Fail first" means a protocol by a healthcare insurer requiring that a healthcare service preferred by a healthcare insurer shall fail to help a patient before the patient receives coverage for the healthcare service ordered by the patient's healthcare provider;

(2) "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 the state;

(3)(A) "Healthcare insurer" means an insurance company, a health

maintenance organization, a hospital and medical service corporation, and a self-insured health plan for employees of a governmental entity.

(B) "Healthcare insurer" does not include workers' compensation plans or Medicaid;

(4) "Healthcare provider" means a doctor of medicine, a doctor of osteopathy, or another health care professional acting within the scope of practice for which he or she is licensed;

(5) "Healthcare service" means a health care procedure, treatment, service, or product, including without limitation prescription drugs and durable medical equipment ordered by a health care provider;

(6) "Medicaid" means the state-federal medical assistance program established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq;

(7) "Prior authorization" means the process by which a healthcare insurer or a healthcare insurer's contracted private review agent determines the medical necessity or medical appropriateness, or both of otherwise covered healthcare services before the rendering of the healthcare services including without limitation:

(A) Preadmission review;

(B) Pretreatment review;

(C) Utilization review;

(D) Case management; and

(E) Any requirement that a patient or healthcare provider notify the healthcare insurer or a utilization review agent before providing a healthcare service.

(8)(A) "Private review agent" means a nonhospital-affiliated person or entity performing utilization review on behalf of:

(i) An employer of employees in the State of Arkansas; or

(ii) A third party that provides or administers hospital and medical benefits to citizens of this state, including:

(a) A health maintenance organization issued a certificate of authority under and by virtue of the laws of the State of Arkansas; and

(b) A health insurer, nonprofit health service plan, health insurance service organization, or preferred provider

organization or other entity offering health insurance policies, contracts, or benefits in this state.

(B) "Private review agent" includes a healthcare insurer if the healthcare insurer performs prior authorization determinations.

(C) "Private review agent" does not include automobile, homeowner, or casualty and commercial liability insurers or their employees, agents, or contractors;

(9) "Step therapy" means a protocol by a healthcare insurer requiring that a patient not be allowed coverage of a prescription drug ordered by the patient's healthcare provider until other less expensive drugs have been tried;

(b) The purpose of this section is to ensure that prior authorization determination protocols safeguard a patient's best interests.

(c)(1) An adverse prior authorization determination made by a utilization review agent shall be based on the medical necessity or appropriateness of the health care services and shall be based on written clinical criteria.

(2) An adverse prior authorization determination shall be made by a qualified health care professional.

(d) This section applies to a healthcare insurer whether or not the healthcare insurer is acting directly or through a private review agent.

(e) If the patient or the patient's healthcare provider, or both receive verbal notification of the adverse prior authorization determination, the qualified healthcare professional who makes an adverse prior authorization determination shall provide the information required for the written notice under subdivision (f)(1) of this section.

(f) Written notice of an adverse prior authorization determination shall be provided to the patient and the patient's healthcare provider requesting the prior authorization by fax or hard copy letter sent by regular mail, as requested by the patient's healthcare provider.

(g) The written notice required under subsection (e) of this section shall include:

(1)(A) The name, title, address, and telephone number of healthcare professional responsible for making the adverse determination.

(B) For a physician, the notice shall identify the physician's board certification status or board eligibility.

(C) The notice under this subsection shall identify each state in which the health care professional is licensed and the license number issued to the professional by each state;

(2) The written clinical criteria, if any, and any internal rule, guideline, or protocol on which the health care insurer relied when making the adverse prior authorization determination and how those provisions apply to the patient's specific medical circumstance;

(3) Information for the patient and the patient's healthcare provider through which the patient or healthcare provider may request a copy of any report developed by personnel performing the utilization review that led to the adverse prior authorization determination; and

(4)(A) Information explaining to the patient and the patient's healthcare provider of the right to appeal the adverse prior authorization determination.

(B) The information required under subdivisions (f)(4)(A) of this section shall include instructions concerning how an appeal may be perfected and how the patient and the patient's healthcare provide may ensure that written materials supporting the appeal will be considered in the appeal process.

(C) The information required under subdivision (f)(4)(A) of this section shall include addresses and telephone numbers to be used by health care providers and patients to make complaints to the Arkansas Medical Board, the State Board of Health, and the State Insurance Department.

(h)(1) When a healthcare service for the treatment or diagnosis of any medical condition is restricted or denied for use by prior authorization or step therapy or a fail first protocol in favor of a healthcare service preferred by the healthcare insurer, the patient's healthcare provider shall have access to a clear and convenient process to expeditiously request an override of that restriction or denial from the healthcare insurer.

(2) Upon request, the patient's health care provider shall be provided contact information, including a phone number, for the person or persons who should be contacted to initiate the request for an expeditious override of the restriction or denial.

(i) Requested healthcare services shall be deemed preauthorized if a healthcare insurer fails to comply with this section.

/s/Irvin