Stricken language would be deleted from and underlined language would be added to present law.

State of Arkansas
89th General Assembly
Regular Session, 2013

A Bill

SENATE BILL 218

By: Senator Irvin

For An Act To Be Entitled

AN ACT TO CREATE A UNIFORM PRIOR AUTHORIZATION FORM; TO REQUIRE HEALTH CARE INSURERS TO USE A UNIFORM PRIOR AUTHORIZATION FORM; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO CREATE A UNIFORM PRIOR AUTHORIZATION FORM; TO REQUIRE HEALTH CARE INSURERS TO USE A UNIFORM PRIOR AUTHORIZATION FORM.

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:

23-99-421. Uniform prior authorization form required — Criteria.

(a) As used in this section:

(1)(A) "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 and the plans providing health benefits to state and public school employees under § 21-5-401 et seq., but excluding individual major medical plans and plans providing health care services 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.

(B) "Health benefit plan" does not include an accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policy;

1 and
2 (2) "Health care insurer" means any insurance company, hospital
3 and medical service corporation, or health maintenance organization issuing
4 or delivering health benefit plans in this state and subject to any of the
5 following laws:
6 (A) The insurance laws of this state;
7 (B) Section 23-75-101 et seq., pertaining to hospital and
8 medical service corporations; and
9 (C) Section 23-76-101 et seq., pertaining to health
10 maintenance organizations.
11 (b) On and after January 1, 2014, a health care insurer that provides
12 prescription drug benefits shall accept only the prior authorization form
13 developed under this section when requiring prior authorization for a
14 prescription drug benefit.
15 (c) If a health care insurer fails to use or accept the prior
16 authorization form developed under this section or fails to respond within
17 two (2) business days upon receipt of a completed prior authorization request
18 from a prescribing provider, pursuant to the submission of the prior
19 authorization form developed under this section, the prior authorization
20 request is granted.
21 (d)(1) The Insurance Commissioner shall develop a uniform prior
22 authorization form.
23 (2) On and after January 1, 2014:
24 (A) A health care insurer shall use the uniform prior
25 authorization form developed under this section to request prior
26 authorization for coverage of a prescription drug benefit; and
27 (B) A health care insurer shall accept the prior
28 authorization form developed under this section as sufficient to request
29 prior authorization for a prescription drug benefit.
30 (e) The prior authorization form developed under this section shall:
31 (1) Not exceed two (2) pages;
32 (2) Be made available electronically by the commissioner; and
33 (3) Be designed to be submitted electronically from a
34 prescribing provider to a health care insurer.
35 (f) The commissioner shall develop the prior authorization form
36 required under this section in consultation with interested parties at one

(1) or more public meetings.

(g) In developing the prior authorization form required under this section, the commissioner shall take into consideration:

(1) Existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services and health care insurers in this state; and

(2) National standards or draft standards pertaining to electronic prior authorization.