State of Arkansas *As Engrossed: S3/12/15*
90th General Assembly **A Bill**
Regular Session, 2015 SENATE BILL 318

By: Senator Irvin

For An Act To Be Entitled

AN ACT TO ESTABLISH THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO ENSURE TRANSPARENCY IN USE OF PRIOR AUTHORIZATIONS FOR MEDICAL TREATMENT; AND FOR OTHER PURPOSES.

Subtitle

TO ESTABLISH THE PRIOR AUTHORIZATION TRANSPARENCY ACT; AND TO ENSURE TRANSPARENCY IN USE OF PRIOR AUTHORIZATIONS FOR MEDICAL TREATMENT.

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

SECTION 1. Arkansas Code § 23-99-420 is repealed.

~~*23-99-420. Prior authorization.*~~

~~*(a) 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 healthcare services issued or delivered by a healthcare insurer in the state;*~~

~~*(3)(A) "Healthcare insurer" means an insurance company, a health maintenance organization, and a hospital and medical service corporation.*~~

~~*(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 healthcare professional acting within the scope of practice for which he or she is licensed;~~

~~(5) "Healthcare service" means a healthcare procedure, treatment, service, or product, including without limitation prescription drugs and durable medical equipment ordered by a healthcare 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) "Self-insured health plan for employees of governmental entity" means a trust established under §§ 14-54-101 and 25-20-104 to provide benefits such as accident and health benefits, death benefits, dental benefits, and disability income benefits; and~~

~~(10) "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 healthcare services and shall be based on written clinical criteria.~~

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

~~(d) This section applies to a healthcare insurer whether or not the healthcare insurer is acting directly or indirectly or through a private review agent and to a self-insured health plan for employees of governmental entities. However, a self-insured plan for employees of governmental entities is not subject to subdivision (g)(4)(C) of this section or oversight by the Arkansas State Medical Board, State Board of Health, or the State Insurance Department.~~

~~(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 (g)(1) of this section.~~

~~(f) Written notice of an adverse prior authorization determination shall be provided to 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 the 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 healthcare 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 healthcare 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 the right to appeal the adverse prior authorization determination.*~~

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

~~*(C) The information required under subdivision (g)(4)(A) of this section shall include addresses and telephone numbers to be used by healthcare providers and patients to make complaints to the Arkansas State 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 healthcare 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 or self-insured health plan for employees of governmental entities fails to comply with this section.*~~

~~*(j)(1) On and after January 1, 2014, to establish uniformity in the submission of prior authorization forms, a healthcare insurer shall utilize only a single standardized prior authorization form for obtaining a prior authorization in written or electronic form for prescription drug benefits.*~~

~~*(2) A healthcare insurer may make the form required under subdivision (j)(1) of this section accessible through multiple computer operating systems.*~~

~~*(3) The prior authorization form required under subdivision (j)(1) of this section shall:*~~

~~*(A) Not exceed two (2) pages; and*~~

~~*(B) Be designed to be submitted electronically from a prescribing provider to a healthcare insurer.*~~

~~*(4) This subsection does not prohibit a prior authorization by verbal means without a form.*~~

~~*(5) If a healthcare insurer fails to use or accept the prior authorization form developed under this subsection or fails to respond as soon as reasonably possible but no later than seventy-two (72) hours after receipt of a completed prior authorization request using the form developed under this subsection, the prior authorization request is granted.*~~

~~*(6)(A) On and after January 1, 2014, each healthcare insurer shall submit its prior authorization form to the State Insurance Department to be kept on file.*~~

~~*(B) A copy of a subsequent replacement or modification of a healthcare insurer's prior authorization form shall be filed with the department within fifteen (15) days before the prior authorization form is used or before implementation of the replacement or modification.*~~

SECTION 2. Arkansas Code Title 23, Chapter 99, is amended to add an additional subchapter to read as follows:

Subchapter 9 — Prior Authorization Transparency Act

23-99-901. Title.

This subchapter shall be known and may be cited as the "Prior Authorization Transparency Act".

23-99-902. Legislative findings and intent.

(a) The General Assembly finds that:

(1) A physician-patient relationship is paramount and should not be subject to third-party intrusion; and

(2) Prior authorizations can place attempted cost savings ahead of optimal patient care.

(b) The General Assembly intends for this subchapter to:

(1) Ensure that prior authorizations do not hinder patient care or intrude on the practice of medicine; and

(2) Guarantee that prior authorizations include the use of written clinical criteria and reviews by appropriate physicians to secure a fair authorization review process for patients.

23-99-903. Definitions.

As used in this subchapter:

(1)(A) "Adverse determination" means a decision by a utilization review entity to deny, reduce, or terminate coverage for a healthcare service furnished or proposed to be furnished to a subscriber on the basis that the healthcare service is not medically necessary or is experimental or investigational in nature.

(B) "Adverse determination" does not include a decision to deny, reduce, or terminate coverage for a healthcare service on any basis other than medical necessity or that the healthcare service is experimental or investigational in nature;

(2) "Authorization" means that a utilization review entity has:

(A) Reviewed the information provided concerning a healthcare service furnished or proposed to be furnished;

(B) Found that the requirements for medical necessity and appropriateness of care have been met; and

(C) Determined to pay for the healthcare *service according to the provisions of the health benefit plan;*

(3) "Clinical criteria" means any written policy, written screening procedures, drug formularies, lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of a healthcare service;

(4) "Emergency healthcare service" means a healthcare service provided in a fixed facility in the first few hours after an injury or after the onset of an acute medical or obstetric condition that manifests itself by one (1) or more symptoms of such severity, including severe pain, that in the absence of immediate medical care would reasonably be expected to result in:

(A) Serious impairment of bodily function;

(B) Serious dysfunction of or damage to any bodily organ or part; or

(C) Death or threat of death;

(5) "Expedited prior authorization" means prior authorization and notice of that prior authorization for an urgent healthcare service to a subscriber or the subscriber's healthcare provider within one (1) business day after the utilization review entity receives all information needed to *complete the review of the requested urgent healthcare service;*

(6) "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;

(7) "Health benefit plan" means any individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by a healthcare insurer in this state;

(8)(A) "Healthcare insurer" means an insurance company, health maintenance organization, and a hospital and medical service corporation.

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

(9) "Healthcare provider" means a doctor of medicine, a doctor of osteopathy, or another licensed health care professional acting within the professional's licensed scope of practice;

(10)(A) "Healthcare service" means a healthcare procedure, treatment, or service:

(i) Provided by a facility licensed in *this state or in the state where the facility is located;* or

(ii) Provided by a doctor of medicine, a doctor of osteopathy, or by a healthcare professional within the scope of practice for which the healthcare professional is licensed in this state.

(B) "Healthcare service" includes the provision of pharmaceutical products or services or durable medical equipment;

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

(12) "Medically necessary healthcare service" means a healthcare service that a healthcare provider provides to a patient in a manner that is:

(A) In accordance with generally accepted standards of medical practice;

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(C) Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating *physician, or other healthcare provider;*

(13) "Nonmedical approval" means a decision by a utilization review entity to approve coverage and payment for a healthcare service according to the provisions of the health benefit plan on any basis other than whether the healthcare service is medically necessary or is experimental or investigational in nature;

(14) "Nonmedical denial" means a decision by a utilization review entity to deny, reduce, or terminate coverage for a healthcare service on any basis other than whether the healthcare service is medically necessary or the healthcare service is experimental or investigational in nature;

(15) "Nonmedical review" means the process by which a utilization review entity decides to approve or deny coverage of or payment for a healthcare service before or after it is given on any basis other than whether the healthcare service is medically necessary or the healthcare service is experimental or investigational in nature;

(16)(A) "Prior authorization" means the process by which a utilization review entity determines the medical necessity and medical appropriateness of *an otherwise covered healthcare service* before the

healthcare service is rendered, including without limitation preadmission review, pretreatment *review, utilization review, and case management.*

(B) "Prior authorization" may include the requirement by a health insurer or a utilization review entity that a subscriber or healthcare provider notify the health insurer or utilization review entity of the subscriber's intent to receive a healthcare service before the healthcare *service is provided;*

(17) "Self-insured health plan for employees of governmental entity" means a trust established under § 14-54-101 et seq. or § 25-20-104 to provide benefits such as accident and health benefits, death benefits, disability benefits, and disability income benefits;

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

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

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

(20) "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:

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

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

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

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

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

(i) An employer with employees in this state who are

covered under a health benefit plan or health insurance policy;

(ii) An insurer that writes health insurance policies;

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

(iv) 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, plan, or contract.

(B) A health insurer is a utilization review entity if it *performs prior authorization.*

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

23-99-904. Disclosure required.

(a)(1) A utilization review entity shall post all of its prior *authorization and nonmedical review requirements* and restrictions, including any written clinical criteria, on the public part of its website.

(2) The information described in subdivision (a)(1) of this section shall be explained in detail and in clear and ordinary terms.

(b) Before a utilization review entity implements a new or amended prior authorization or nonmedical review requirement or restriction as described in subdivision (a)(1) of this section, the utilization review entity shall update its website to reflect the new or amended requirement or restriction.

(c) Before implementing a new or amended prior authorization or nonmedical review requirement or restriction, a utilization review entity shall provide contracted healthcare providers written notice of the new or amended requirement or restriction at least sixty (60) days before implementation of the new or amended requirement or restriction.

(d)(1) A utilization review entity shall make statistics available regarding prior authorization approvals and denials and nonmedical approvals and denials on its website in a readily accessible format.

(2) The utilization review entity shall include categories for:

(A) Physician specialty;

(B) Medication or a diagnostic test or procedure;

(C) Indication offered; and

(D) Reason for denial.

23-99-905. Prior authorization – Nonurgent healthcare service.

(a) If a utilization review entity requires prior authorization of a nonurgent healthcare service, the utilization review entity shall *make an authorization or adverse determination and notify the subscriber and the subscriber's nonurgent healthcare provider of the decision within two (2) business days of obtaining all necessary information to make the authorization or adverse determination.*

(b) For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

23-99-906. Prior authorization - Urgent healthcare service.

A utilization review entity shall render an *expedited* authorization or *adverse* determination concerning an urgent healthcare service and notify the subscriber and the subscriber's healthcare provider of that expedited prior authorization or adverse determination *no later* than one (1) business day after receiving all information needed to complete the review of the requested urgent healthcare service.

23-99-907. Prior authorization – Emergency healthcare service.

(a) A utilization review entity shall not require prior authorization for prehospital transportation or for provision of an emergency healthcare service.

(b)(1) A utilization review entity shall allow a subscriber and the subscriber's healthcare provider a minimum of twenty-four (24) hours following an emergency admission or provision of an emergency healthcare service for the subscriber or healthcare provider to notify the utilization review entity of the admission or provision of an emergency healthcare service.

(2) If the admission or emergency healthcare service occurs on a holiday or weekend, a utilization review entity shall not require notification until the next business day after the admission or provision of

the emergency healthcare service.

(c)(1) A utilization review entity shall cover emergency healthcare services necessary to evaluate and assess the health condition of a *subscriber or to* stabilize a subscriber.

(2) If a healthcare provider certifies in writing to a utilization review entity within seventy-two (72) hours of a subscriber's admission that the subscriber's condition required an emergency healthcare service, that certification will create a presumption that the emergency healthcare service was medically necessary, and such presumption may be rebutted only if the utilization review entity can establish, with clear and convincing evidence, that the emergency healthcare service was not medically necessary.

(d)(1) The determination by a utilization review entity of medical necessity or medical appropriateness of an emergency healthcare service shall not be based on whether the emergency healthcare service was provided by a *healthcare provider that is a member of the health benefit plan's provider network.*

(2) Restrictions on coverage for an emergency healthcare service provided by a healthcare provider that is not a member of the health benefit plan's provider network shall not be greater than restrictions on coverage for an emergency healthcare service provided by a healthcare provider that is a member of the health benefit plan's provider network.

(e)(1) If a subscriber receives an emergency healthcare service that requires an immediate post-evaluation or post-stabilization healthcare service, a utilization review entity shall make an authorization within sixty (60) minutes of receiving a request.

(2) If the authorization is not made within sixty (60) minutes, the emergency healthcare service shall be approved.

23-99-908. Retrospective denial.

(a) A utilization review entity shall not revoke, limit, condition, or restrict *an authorization* for a period of forty-five (45) business days from the date the healthcare provider received the *authorization.*

(b) Any correspondence, contact, or other action by a utilization review entity that disclaims, denies, attempts to disclaim, or attempts to deny payment for healthcare services that have been *authorized within* the

forty-five-day period under subsection (a) of this section is void.

23-99-909. Waiver prohibited.

(a) The provisions of this subchapter shall not be waived by contract.

(b) Any contractual arrangements or actions taken in conflict with this subchapter or that purport to waive any requirements of this subchapter *are void.*

23-99-910. State physician required.

A physician shall be licensed by the Arkansas State Medical Board before making recommendations or decisions regarding prior authorization or nonmedical review requests.

23-99-911. Application.

(a) This subchapter applies to:

(1) A healthcare insurer whether or not the healthcare insurer is acting directly or indirectly through a private utilization review entity; and

(2)(A) A self-insured health plan for employees of governmental entities.

(B) A self-insured plan for employees of governmental entities is not subject to § 23-99-912(b)(4)(C) or the Arkansas State Medical Board, State Board of Health, or the State Insurance Department.

(b) This subchapter applies to any healthcare service, whether or not the health benefit plan requires prior authorization or nonmedical review for the healthcare service.

(c) A request by a healthcare provider for authorization or approval of a service regulated under this subchapter before it is given shall be subject to this subchapter.

23-99-912. Form of notice.

(a)(1) Notice of an adverse determination or a nonmedical denial shall be provided to the healthcare provider that initiated the prior authorization or nonmedical review.

(2) Notice may be made by fax or hard copy letter sent by regular mail or verbally, as requested by the subscriber's healthcare

provider.

(b) The written or verbal notice required under this section shall include:

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

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

(C) The notice under this section shall identify each state in which the healthcare 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 healthcare insurer relied when making the adverse determination or nonmedical denial and how those provisions apply to the subscriber's specific medical circumstance;

(3) Information for the subscriber and the subscriber's healthcare provider that describes the procedure through which the subscriber or healthcare provider may request a copy of any report developed by personnel performing the review that led to the adverse determination or nonmedical denial; and

(4)(A) Information that explains to the subscriber and the subscriber's healthcare provider the right to appeal the adverse determination or nonmedical denial.

(B) The information required under subdivision (b)(4)(A) of this section shall include instructions concerning how to perfect an appeal and how the subscriber and the subscriber's healthcare provider may ensure that written materials supporting the appeal will be considered in the appeal process.

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

(c)(1) When a healthcare service for the treatment or diagnosis of any medical condition is restricted or denied for use by nonmedical review, step therapy, or a fail first protocol in favor of a healthcare service preferred by the healthcare insurer, the subscriber'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 subscriber's healthcare provider shall be provided contact information, including a phone number, for a person to initiate the request for an expeditious override of the restriction or denial.

(d) The appeal process described in subdivision (b)(2), subdivision (b)(3), and subdivision (b)(4) of this section shall not apply when a healthcare service is denied due to the fact that the healthcare service is not a covered service under the health benefit plan.

23-99-913. Deemed approval.

If a healthcare insurer or self-insured health plan for employees of governmental entities fails to comply with this subchapter, the requested healthcare services shall be deemed authorized or approved.

23-99-914. Standardized form required.

(a) On and after January 1, 2014, to establish uniformity in the submission of prior authorization and nonmedical review forms, a healthcare insurer shall utilize only a single standardized prior authorization and nonmedical review form for obtaining approval in written or electronic form for prescription drug benefits.

(b) A healthcare insurer may make the form required under subsection (a) of this section accessible through multiple computer operating systems.

(c) The form required under subsection (a) of this section shall:

(1) Not exceed two (2) pages; and

(2) Be designed to be submitted electronically from a prescribing provider to a healthcare insurer.

(d) This section does not prohibit prior authorization or nonmedical review by verbal means without a form.

(e) If a healthcare insurer fails to use or accept the form developed under this section or fails to respond as soon as reasonably possible, but no later than one (1) business day for prior authorizations for urgent healthcare services, sixty (60) minutes for emergency healthcare services, or seventy-two (72) hours for all other services, after receipt of a completed prior authorization or nonmedical review request using the form developed

under this section, the prior authorization or nonmedical review request is deemed authorized or approved.

(f)(1) On and after January 1, 2014, each healthcare insurer shall submit its prior authorization and nonmedical review form to the State Insurance Department to be kept on file.

(2) A copy of a subsequent replacement or modification of a healthcare insurer's prior authorization and nonmedical review form shall be filed with the department within fifteen (15) days before the form is used or before implementation of the replacement or modification.

/s/Irvin