State of Arkansas *As Engrossed: H2/20/25 H3/3/25*
95th General Assembly **A Bill**
Regular Session, 2025 HOUSE BILL 1300

By: Representative L. Johnson
By: Senator Irvin

For An Act To Be Entitled

AN ACT TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO MODIFY THE DEFINITION OF "PRIOR AUTHORIZATION" UNDER THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO CLARIFY DISCLOSURE REQUIREMENTS; TO REQUIRE ADDITIONAL DISCLOSURES BY A UTILIZATION REVIEW ENTITY UNDER THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO EXEMPT CERTAIN HEALTHCARE SERVICES FROM PRIOR AUTHORIZATION; TO CLARIFY THE DURATION OF APPROVED PRIOR AUTHORIZATION REQUESTS; TO CREATE A PROCESS FOR REVIEW OR APPROVAL OF A HEALTHCARE SERVICE UPON FAILURE OF A UTILIZATION REVIEW ENTITY TO COMPLY WITH THE PRIOR AUTHORIZATION TRANSPARENCY ACT; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY ACT.

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

SECTION 1. Arkansas Code Title 19, Chapter 5, Subchapter 11, is amended to add an additional section to read as follows:

19-5-1161. Prior Authorization Transparency Act Trust Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the “Prior Authorization Transparency Act Trust Fund”.

(b) The fund shall consist of all moneys received by the Insurance

Commissioner for the fines under § 23-99-1116.

(c)(1) The fund shall be administered by and disbursed at the direction of the commissioner.

(2) Moneys shall not be appropriated from the fund for any purpose except:

(A) To inform and educate healthcare providers and subscribers about the requirements of the Prior Authorization Transparency Act, § 23-99-1101 et seq.; and

(B) To improve the ability of the State Insurance Department to:

(i) Assess compliance with the Prior Authorization Transparency Act, § 23-99-1101 et seq.;

(ii) Assess compliance with other laws and regulations applicable to healthcare insurers and utilization review entities; and

(iii) Improve enforcement of state law and rules applicable to a healthcare insurer, utilization review entity, healthcare contracting entity, and other related entities.

(d) All moneys deposited into the fund shall not be subject to a deduction, tax, levy, or other type of assessment.

SECTION 2. Arkansas Code § 23-99-1103(10), concerning the definition of "health service" under the Prior Authorization Transparency Act, is amended to read as follows:

(10)(A) "Healthcare service" means a healthcare procedure, treatment, or service provided by a healthcare provider.

(B) "Healthcare service" includes without limitation the provision of pharmaceutical products or services or durable medical equipment and a service identifiable by:

(i) The Current Procedural Terminology code;

(ii) The Healthcare Common Procedure Coding System code; or

(iii) The National Drug Code;

SECTION 3. Arkansas Code § 23-99-1103(15), concerning the definition of "prior authorization" under the Prior Authorization Transparency Act, is

amended to read as follows:

(15)(A) "Prior authorization" means ~~the process by which a utilization review entity determines the medical necessity of an otherwise covered healthcare service before the healthcare service is rendered, including without limitation preadmission review, pretreatment review, utilization review, case management, and fail first protocol~~ a process, requirement, or administrative function mandated by a utilization review entity that shall be completed by a healthcare provider or subscriber as a condition of coverage determination or condition of payment determination for a healthcare service before the healthcare service is rendered.

(B) "Prior authorization" ~~may include~~ includes without limitation:

(i) Preadmission review;

(ii) Pretreatment review;

(iii) Precertification;

(iv) Predetermination;

(v) Prospective utilization review;

(vi) Concurrent review;

(vii) Fail first protocols;

(viii) Medical necessity determination;

(ix) Prior notification; and

(x) ~~the~~ The requirement 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;

SECTION 4. Arkansas Code § 23-99-1104 is amended to read as follows:

23-99-1104. Disclosure required.

(a)(1)(A) A utilization review entity shall disclose all of its prior authorization requirements, clinical criteria, and restrictions in a publicly accessible manner on its website.

(B) The disclosure under subdivision (a)(1)(A) of this section shall be explained in detail and in clear and ordinary terms, and include:

(i)(a) A list of any healthcare services that require prior authorization.

(b) The list under subdivision (a)(1)(B)(i)(a) of this section shall:

(1) Be available in a format that can be easily understood by a subscriber and in a machine-readable format that allows for automated retrieval and processing; and

(2) Include the following information:

(A) The name of the healthcare service and any billing codes associated with the healthcare service; and

(B)(i) The effective date and end date of the prior authorization requirement.

(ii) A healthcare service that no longer requires a prior authorization shall remain on the list for ten (10) years;

(ii)(a) Any written clinical criteria for services that require prior authorizations.

(b) The information described in subdivision (a)(1)(B)(ii)(a) of this section shall be explained in detail and in clear and ordinary terms; and

(iii) Any written clinical criteria for services that do not require prior authorization but are subject to review for medical necessity.

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

~~(3)(A)~~(2)(A) Utilization review entities that have agreed, by contract with vendors or third-party administrators, to use licensed, proprietary, or copyrighted protected clinical criteria from the vendors or administrators may satisfy the disclosure requirement under subdivision (a)(1) of this section by making all relevant proprietary clinical criteria available to a healthcare provider that submits a prior authorization request to the utilization review entity through a secured link on the utilization review entity's website that is accessible to the healthcare provider from the public part of its website as long as any link or access restrictions to the information do not cause any delay to the healthcare provider.

(B) For out-of-network providers, a utilization review entity may meet the requirements of this subdivision ~~(a)(3)~~(a)(2) by:

(i) Providing the healthcare provider with temporary

electronic access in a timely manner to a secure site to review copyright-protected clinical criteria; or

(ii) Disclosing copyright-protected clinical criteria in a timely manner to a healthcare provider through other electronic or telephonic means.

(b) Before a utilization review entity implements a new or amended prior authorization requirement, clinical criteria, 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)(1) Before implementing a new or amended prior authorization requirement, clinical criteria, 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.

(2) As used in subdivision (c)(1) of this section, "written notice" means actual notice to the healthcare provider via mail, email, or *fax.*

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

(2) The statistics made available by a utilization review entity under this subsection shall categorize approvals and denials by:

(A) Physician specialty;

(B) Medication or diagnostic test or procedure;

(C) Medical indication offered as justification for the prior authorization request; and

(D) Reason for denial.

SECTION 5. Arkansas Code § 23-99-1104, concerning the disclosure requirements under the Prior Authorization Transparency Act, is amended to add an additional subsection to read as follows:

(e) If a utilization review entity provides information to a healthcare provider indicating that a prior authorization is not required for a specific healthcare service, then the utilization review entity shall disclose any other restriction, limitation, or requirement that may preclude

coverage of the specific healthcare service, including without limitation:

(1) A step therapy requirement;

(2) A restriction on the place of the specific healthcare service;

(3) A restriction on the healthcare provider type or benefit category;

(4) Clinical criteria that completely excludes the specific healthcare service from coverage; and

(5) Any post-service review, information request, or audit responsibility that is applicable to the specific healthcare service.

SECTION 6. Arkansas Code § 23-99-1109(c), concerning payment of a claim by a healthcare insurer regardless of terminology under the Prior Authorization Transparency Act, is amended to read as follows:

(c) A healthcare insurer shall pay a claim for a healthcare service for which prior authorization was received regardless of the terminology used by the utilization review entity or health benefit plan when reviewing the claim, unless:

(1) The authorized healthcare service was never performed;

(2) The submission of the claim for the healthcare service with respect to the subscriber was not timely under the terms of the applicable provider contract or policy;

(3) The subscriber had not exhausted contract or policy benefit limitations based on information available to the utilization review entity or healthcare insurer at the time of the authorization but subsequently exhausted contract or policy benefit limitations after the authorization was issued, in which case the utilization review entity or healthcare insurer shall include language in the notice of authorization to the subscriber and healthcare provider that the visits or services authorized might exceed the limits of the contract or policy and would accordingly not be covered under the contract or policy;

(4) There is specific information available for review by the appropriate state or federal agency that the subscriber or healthcare provider has engaged in material misrepresentation, fraud, or abuse regarding the claim for the authorized service; or

(5) ~~The~~ For a healthcare service that is a procedure identified

by a numerical Current Procedural Terminology code and not by an alphanumerical Healthcare Common Procedure Coding System code, the authorization was granted more than ninety (90) days before the authorized healthcare service is provided if the healthcare service is a procedure.

SECTION 7. Arkansas Code § 23-99-1109, concerning rescission of prior authorizations, denial of payment for prior authorized services, and limitations under the Prior Authorization Transparency Act, is amended to add an additional subsection to read as follows:

(f) A healthcare insurer shall pay a claim for a healthcare service in the absence of a prior authorization if:

(1) At the time the healthcare service was provided, the patient *had been covered by a health benefit plan for ninety (90) days or less; and*

(2) The healthcare service is part of a course of treatment initiated before the patient is covered by the health benefit plan.

SECTION 8. Arkansas Code § 23-99-1111(b), concerning the approval of requests under the Prior Authorization Transparency Act, is amended to read as follows:

(b)(1) A request for prior authorization may be approved by a qualified person employed or contracted by a utilization review entity.

(2)(A) The prior authorization under subdivision (b)(1) of this section shall:

(i) Be issued for the entire course of treatment based on a range of dates; and

(ii) Include a period as long as medically reasonable and necessary to avoid disruptions in care.

(B) If the prior authorization includes an indication for a number of units, visits, or administrations, the authorized number of units, visits, or administrations shall be sufficient for the entire course of treatment.

SECTION 9. Arkansas Code § 23-99-1116 is amended to read as follows:

23-99-1116. Failure to comply with subchapter — ~~Requested healthcare services deemed approved~~ Enforcement — Fines.

(a)(1) ~~If~~ For any provision of this subchapter that relates to a

specific request from a healthcare provider for a prior authorization, if a healthcare insurer or utilization review entity fails to comply with this subchapter, the requested healthcare services shall be deemed authorized or approved.

(2) Within one (1) business day after a healthcare provider provides notice that the healthcare insurer or utilization review entity has failed to comply with this subchapter, the healthcare insurer or utilization review entity shall:

(A) Issue the authorization for the requested healthcare *service;*

(B) Resend to a healthcare provider any request for information previously sent to, and unanswered by, the healthcare provider; or

(C)(i) Refer the matter to the State Insurance Department for review.

(ii) If the matter is referred to the department under *subdivision (a)(2)(C)(i)* of this section, then after notice to the healthcare insurer or utilization review entity, the Insurance Commissioner *may conduct an investigation and hold a hearing under § 23-66-209, to* determine whether or not the healthcare insurer or utilization review entity failed to comply with this subchapter.

(iii) If the commissioner finds that the healthcare insurer or utilization review entity failed to comply with this subchapter, then the commissioner *may order* the healthcare insurer or utilization review entity to:

(a) Issue the authorization for the requested *healthcare service;*

(b) Pay the costs of a hearing; and

(c)(1) Pay a monetary penalty as described in § 23-66-210(a)(1) of not more than one thousand dollars ($1,000) for each violation, not to exceed an aggregate penalty of ten thousand dollars ($10,000), unless the person knew or reasonably should have known he or she was in violation of this subchapter.

(2) If a person knew or reasonably should have known he or she was in violation of this subchapter, the penalty

under subdivision (c)(1) of this section shall not be more than five thousand dollars ($5,000) for each violation, not to exceed an aggregate penalty amount of fifty thousand dollars ($50,000) in any six-month period.

(iv) If the commissioner finds that a healthcare insurer or utilization review entity has complied with this subchapter, then the commissioner and the department shall provide notice to:

(a) The healthcare insurer or utilization review entity; and

(b) The requesting healthcare provider.

(b) A healthcare service that is authorized or approved under subsection (a) of this section is not subject to audit recoupment under § 23-63-1801 et seq.

(c)(1) For any provision of this subchapter not subject to subsection (a) of this section, if a healthcare insurer or utilization review entity fails to comply with this subchapter, a healthcare provider may provide notice to the healthcare insurer or utilization review entity of the failure to comply.

(2) Within (1) business day after a healthcare provider provides notice that the healthcare insurer or utilization review entity has failed to comply with this subchapter, the healthcare insurer or utilization review entity shall:

(A) Take action to address the failure retrospectively and prospectively to ensure compliance; or

(B)(i) Refer the matter to the department for review.

(ii) If the matter is referred to the department under subdivision (c)(2)(B)(i) of this section or by a complaint filed by a healthcare provider or a subscriber, the commissioner *may conduct an investigation and hold a hearing under § 23-66-209* to determine whether or not the healthcare insurer or utilization review *entity failed to comply with this subchapter with such frequency as to indicate a general business practice.*

(iii) If the commissioner finds that the healthcare insurer or utilization review entity failed to comply with this *subchapter with such frequency as to indicate a general business practice*, then the commissioner shall order the healthcare insurer or utilization review entity to:

(a) Take action to address the failure retrospectively and prospectively to ensure compliance; and

(b) Pay a civil fine not to exceed five thousand dollars ($5,000) per day of noncompliance up to one hundred thousand dollars ($100,000).

(C) If the commissioner finds that a healthcare insurer or utilization review entity has complied with this subchapter, then the commissioner and the department shall provide notice to:

(i) The healthcare insurer or utilization review entity; and

(ii) The requesting healthcare provider.

(d) This section does not prohibit a healthcare provider or subscriber from filing a complaint with the department based on a violation of this subchapter.

(e) A fine imposed and collected under this section shall be deposited as special revenues into the State Treasury and credited to the Prior *Authorization Transparency Act Fund.*

(f) A healthcare insurer or utilization review entity does not violate this subchapter if:

(1) The healthcare insurer or utilization review entity requests additional information from the healthcare provider in compliance with this subchapter; and

(2) The healthcare provider fails to send the requested information to the healthcare insurer or utilization review entity.

/s/L. Johnson