ARKANSAS SENATE

90th General Assembly - Regular Session, 2015

Amendment Form

Subtitle of Senate Bill No. 318

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

Amendment No. 1 to Senate Bill No. 318

Amend Senate Bill No. 318 as originally introduced:

Page 1, delete line 23 and substitute the following:

"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 Arkansas Code § 23-99-420 is repealed.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"

AND

Page 1, line 26, delete "Subchapter 8" and substitute "Subchapter 9"

AND

Page 1, line 28, delete "23-66-801." and substitute "23-99-901."

AND

Page 1, line 32, delete "23-66-802." and substitute "23-99-902."

AND

Page 2, line 9, delete "23-66-803." and substitute "23-99-903."

AND

Page 2, line 25, delete "service;" and substitute "service according to the provisions of the health benefit plan;"

AND

Page 3, delete line 9, and substitute the following:
"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;"

AND

Page 3, line 10, delete "(6)(A)" and substitute "(10)(A)"

AND

Page 3, line 12, delete "this state;" and substitute "this state or in the state where the facility is located;"

AND

Page 3, delete lines 19 through 22, and substitute the following:

"(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:"

AND

Page 3, delete line 29, and substitute the following:

"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;"

AND

Page 3, line 30, delete "(8)(A)" and substitute "(16)(A)"

AND

Page 3, line 32, delete "a covered healthcare service" and substitute "an otherwise covered healthcare service"

AND

Page 3, delete line 34, and substitute the following:
"review, utilization review, and case management."

AND

Page 4, delete lines 3 through 6, and substitute the following:
"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."

AND

Page 4, line 9, delete "(10)(A)" and substitute "(20)"

AND

Page 4, line 20, delete "care." and substitute "care; and"

AND

Page 4, delete lines 21 through 25 and substitute the following:
"(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:"

AND

Page 5, delete line 1 and substitute the following:
"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."

AND

Page 5, line 3, delete "23-66-804." and substitute "23-99-904."

AND

Page 5, line 5, delete "authorization requirements" and substitute "authorization and nonmedical review requirements"

AND

Page 5, delete lines 9 through 23 and substitute the following:

"(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."

AND

Page 5, line 30, delete "23-66-805." and substitute "23-99-905."

AND

Page 5, line 32, delete "make a" and substitute "make an"

AND

Page 5, delete lines 33 through 36 and substitute the following:
"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."

AND

Page 6, line 5, delete "23-66-806." and substitute "23-99-906."

AND

Page 6, line 6, delete "expedited prior" and substitute "expedited"

AND

Page 6, line 7, delete "an adverse" and substitute "adverse"

AND

Page 6, line 9, delete "not later" and substitute "no later"

AND

Page 6, line 13, delete "23-66-807." and substitute "23-99-907."

AND

Page 6, line 29, delete "subscriber to" and substitute "subscriber or to"

AND

Page 7, delete lines 5 through 9 and substitute the following:
"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."

AND

Page 7, line 17, delete "23-66-808." and substitute "23-99-908."

AND

Page 7, line 19, delete "a prior authorization" and substitute "an authorization"

AND

Page 7, line 20, delete "prior authorization." and substitute "authorization."

AND

Page 7, line 23, delete "preauthorized within" and substitute "authorized within"

AND

Page 7, line 26, delete "23-66-809." and substitute "23-99-909."

AND

Page 7, delete line 30 and substitute the following:
"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."

The Amendment was read the first time, rules suspended and read the second time and _______________________
By: Senator Irvin
ANS/ANS - 03-11-2015 10:54:08
ANS269

____
Secretary