State of Arkansas *As Engrossed: H2/5/25 H2/20/25 H3/13/25*
95th General Assembly
A Bill
Regular Session, 2025 HOUSE BILL 1301

By: Representative L. Johnson
By: Senator Irvin

For An Act To Be Entitled

AN ACT TO AMEND 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 § 23-99-1103, concerning the definitions used in the Prior Authorization Transparency Act, is amended to add an additional subdivision to read as follows:

(23) "Gold card program" means the process described in §§ 23-99-1120 — 23-99-1126 under which a healthcare provider may qualify for an exemption from a healthcare insurer's or pharmacy benefits manager's prior authorization requirements.

SECTION 2. Arkansas Code § 23-99-1120 is amended to read as follows:

23-99-1120. Initial exemption from prior authorization requirements for healthcare providers providing certain healthcare services.

(a)~~(1) Except as provided under subdivision (a)(2) of this section, beginning on and after January 1, 2024, a healthcare provider that received approval for ninety percent (90%) or more of the healthcare provider's prior authorization requests based on a review of the healthcare provider's utilization of the particular healthcare services from January 1, 2022, through June 30, 2022, shall not be required to obtain prior authorization~~

~~for a particular healthcare service and shall be considered exempt from prior authorization requirements through September 30, 2024.~~

~~(2) If a healthcare provider's use for a particular healthcare service increases by twenty-five percent (25%) or more during the period between January 1, 2024, and June 30, 2024, based on a review of the healthcare provider's utilization of the particular healthcare service from January 1, 2022, through June 30, 2022, then the healthcare insurer may disallow the exemption from prior authorization requirements for the healthcare provider for the particular healthcare service.~~

~~(b)(1) A healthcare insurer shall conduct an evaluation of the initial six-month exemption period based on claims submitted between January 1, 2024, through June 30, 2024, to determine whether to grant or deny an exemption for each particular healthcare service that requires a prior authorization by the healthcare insurer.~~

~~(2) The evaluation by the healthcare insurer shall be conducted by using the retrospective review process under § 23-99-1122(c) and applying the criteria under subsection (d) of this section.~~

~~(3) A healthcare insurer shall submit to a healthcare provider a written statement of:~~

~~(A) The total number of payable claims submitted by or in connection with the healthcare provider; and~~

~~(B) The total number of denied and approved prior authorizations between January 1, 2022, through June 30, 2022.~~

~~(c)(1) No later than October 1, 2024, a healthcare insurer shall issue a notice to each healthcare provider that either grants or denies a prior authorization exemption to the healthcare provider for each particular healthcare service.~~

~~(2) An exemption granted under this subdivision (c)(1) shall be valid for at least twelve (12) months.~~

~~(d)~~ Except as provided under ~~subsection (f)~~ subsection (c) of this section or § 23-99-1125, a healthcare insurer that uses a prior authorization process for healthcare services shall not require a healthcare provider to obtain prior authorization for a particular healthcare service that a healthcare provider has previously been subject to a prior authorization requirement if, in the most recent six-month evaluation period as described under ~~subsection (e)~~ subsection (b) of this section, the healthcare insurer

has approved or would have approved no less than ninety percent (90%) of the prior authorization requests submitted by the healthcare provider for that particular healthcare service.

~~(e)(1)~~(b)(1) Except as provided under ~~subsection (f)~~ subsection (c) of this section, a healthcare insurer shall evaluate whether or not a healthcare provider qualifies for an exemption from prior authorization requirements under ~~subsection (d)~~ subsection (a) of this section one (1) time every twelve (12) months.

(2) The six-month period for the evaluation period described under ~~subsection (d)~~ subsection (a) of this section shall be:

(A) For a healthcare provider with an existing exemption under this section, any consecutive six-month period during the twelve (12) months following the effective date of the exemption;

(B) For an initial healthcare provider, any consecutive six-month period during the twelve (12) months following the healthcare provider's first filed claim with the healthcare *insurer;*

(C) For an initial healthcare insurer, any consecutive six-month period during the twelve (12) months following the healthcare *insurer's commencement of operations subject to this subchapter; or*

(D)(i) For a healthcare provider denied an exemption under this section, any consecutive six-month period during the twelve (12) months before the healthcare provider's request for a new evaluation.

(ii) A healthcare provider may request that the healthcare insurer perform a new evaluation twelve (12) months after the most recent denial.

(3) The healthcare insurer shall choose a six-month evaluation period that allows time for:

(A) The evaluation under ~~subsection (d)~~ subsection (a) of this section;

(B) Notice to the healthcare provider of the decision; and

(C) Appeal of the decision for an independent review to be completed by the end of the twelve-month period ~~of the exemption~~.

~~(f)~~(c) A healthcare insurer may continue an exemption under ~~subsection (d)~~ subsection (a) of this section without evaluating whether or not the healthcare provider qualifies for the exemption under ~~subsection (d)~~ subsection (a) of this section for a particular evaluation period.

~~(g)~~(d) A healthcare provider is not required to request an exemption under ~~subsection (d)~~ subsection (a) of this section to ~~quality~~ qualify for the exemption.

~~(h)~~(e)(1) A healthcare insurer ~~may~~ shall extend an exemption under ~~subsection (d)~~ subsection (a) of this section to a group of healthcare providers under the same tax identification number if either the healthcare insurer or the healthcare provider elects to do so, and:

~~(1)~~(A) A healthcare provider with an ownership interest in the entity to which the tax identification number is assigned does not object; or

~~(2)~~(B) The tax identification number is associated with a hospital licensed in this state and the chief executive officer of the hospital agrees to the exemption.

(2) If a healthcare insurer elects to extend an exemption under subdivision (e)(1) of this section to a group of healthcare providers, the healthcare insurer shall provide to each affected healthcare provider at least sixty (60) days' prior notice of the election and of any modification *to or termination of the election.*

(3) If, in the most recent six-month evaluation period, the healthcare insurer approved or would have approved less than eighty percent (80%) of the prior authorization requests submitted by a healthcare provider for a particular healthcare service, the healthcare provider shall not be eligible for inclusion under an exemption extended to healthcare providers under the same tax identification number under this subsection.

SECTION *3*. Arkansas Code § 23-99-1121(a), concerning the duration of a prior authorization exemption under the Prior Authorization Transparency Act, is amended to read as follows:

(a) Unless a prior authorization exemption is continued for a longer period of time by a healthcare insurer under ~~§ 23-99-1120(f)~~ § 23-99-1120(c), a healthcare provider's exemption from prior authorization requirements under § 23-99-1120 remains in effect until the later of:

(1) The thirtieth day after the date the healthcare insurer notifies the healthcare provider of the healthcare insurer's determination to rescind the exemption as described under § 23-99-1122, if the healthcare provider does not appeal the healthcare insurer's determination within thirty

(30) days of notification of the determination;

(2) If the healthcare provider appeals the determination within thirty (30) days of notification of the determination, the fifth day after the date an independent review organization affirms the healthcare insurer's determination to rescind the exemption; or

(3) Twelve (12) months after the effective date of the exemption.

SECTION 4. Arkansas Code § 23-99-1122(a), concerning the recission of a prior authorization exemption under the Prior Authorization Transparency Act, is amended to read as follows:

(a) A healthcare insurer may rescind an exemption from prior authorization requirements of a healthcare provider under § 23-99-1120 only if:

(1) The healthcare insurer makes a determination that, on the basis of a retrospective review of a random sample of claims selected by the healthcare insurer during the most recent evaluation period described by ~~§ 23-99-1120(c)~~ § 23-99-1120(b), less than ninety percent (90%) of the claims for the particular healthcare service met the medical necessity criteria that would have been used by the healthcare insurer when conducting prior authorization review for the particular healthcare service during the relevant evaluation period;

(2) The healthcare insurer complies with other applicable requirements specified in this section, including without limitation:

(A) Notifying the healthcare provider no less than ~~twenty-five (25)~~ thirty (30) days before the proposed rescission is to take effect; and

(B) Providing:

(i) An identification of the healthcare service that an exemption is being rescinded, the date the notice is issued, and the effective date of the rescission;

(ii) A plain-language explanation of how the healthcare provider may appeal and seek an independent review of the determination, the date the notice is issued, and the company's address and contact information for returning the form by mail or email to request an appeal;

(iii) A statement of the total number of payable claims submitted by or in connection with the healthcare provider during the most recent evaluation period that were eligible to be evaluated with respect to the healthcare service subject to rescission, the number of claims included in the random sample, and the sample information used to make the determination, including without limitation:

(a) Identification of each claim included in the random sample;

(b) The healthcare insurer's determination of whether each claim met the healthcare insurer's screening criteria; and

(c) For any claim determined to not have met the healthcare insurer's screening criteria:

(1) The principal reasons for the determination that the claim did not meet the healthcare insurer's screening criteria, including, if applicable, a statement that the determination was based on a failure to submit specified medical records;

(2) The clinical basis for the determination that the claim did not meet the healthcare insurer's screening criteria;

(3) A description of the sources of the screening criteria that were used as guidelines in making the determination; and

(4) The professional specialty of the healthcare provider who made the determination;

(iv) A space to be filled out by the healthcare provider that includes:

(a) The name, address, contact information, and identification number of the healthcare provider requesting an independent review;

(b) An indication of whether or not the healthcare provider is requesting that the entity performing the independent review examine the same random sample or a different random sample of claims, if available; and

(c) The date the appeal is being requested; and

(v) An instruction to the healthcare provider to

return the form to the healthcare insurer before the date the rescission becomes effective; and

(3) The healthcare provider performs five (5) or fewer of a particular healthcare service in the most recent six-month evaluation period under ~~§ 23-99-1120(e)~~ § 23-99-1120(b).

SECTION *5*. Arkansas Code § 23-99-1122(c)(2), concerning the timeline a healthcare insurer provides to a healthcare provider to provide medical records under the Prior Authorization Transparency Act, is amended to read as follows:

(2) A healthcare insurer shall provide a healthcare provider at least ~~thirty (30)~~ sixty (60) days to provide the medical records requested under subdivision (c)(1) of this section.

SECTION *6*. Arkansas Code § 23-99-1126(a), concerning the payments to a healthcare provider who has an exemption under the Prior Authorization Transparency Act, is amended to read as follows:

(a)(1) A healthcare insurer shall not deny or reduce payment to a healthcare provider for a healthcare service for which the healthcare provider has qualified for an exemption from prior authorization requirements under § 23-99-1120, including a healthcare service performed or supervised by another healthcare provider, if the healthcare provider who ordered the healthcare service received a prior authorization exemption based on medical necessity or appropriateness of care unless the healthcare provider:

~~(1)~~(A) Knowingly and materially misrepresented the healthcare service in a request for payment submitted to the healthcare insurer with the specific intent to deceive the healthcare insurer and obtain an unlawful payment from the healthcare insurer; or

~~(2)~~(B) Substantially failed to perform the healthcare service.

(2)(A) Subdivision (a)(1) of this section does not constitute a basis for a healthcare insurer to:

(i) Request information from a healthcare provider; or

(ii) Delay reimbursement in order to obtain information.

(B) A request for information under subdivision (a)(2)(A)(i) of this section shall comply with applicable laws and rules.

SECTION *7*. Arkansas Code § 23-99-1126(d), concerning the information required in the notice to a healthcare provider under the Prior Authorization Transparency Act, is amended to read as follows:

(d) ~~Beginning on January 1, 2024, a~~ A healthcare insurer shall provide to a healthcare provider a notice that includes a:

(1) Statement that the healthcare provider has an exemption from prior authorization requirements under § 23-99-1120;

(2) List of the healthcare services and health benefit plans to which the exemption applies; and

(3) Statement of the duration of the exemption.

SECTION *8*. Arkansas Code § 23-99-1127 is amended to read as follows:

23-99-1127. Applicability.

(a)(1) An organization or entity directly or indirectly providing a plan or services to patients under the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq., or any other Medicaid-managed care program operating in this state is exempt from §§ 23-99-1120 — 23-99-1126 if the program, without limiting the program's application to any other plan or program, develops and conforms to a program to reduce or eliminate prior authorizations for a healthcare provider ~~on or before January 1, 2025~~.

(2) The Arkansas Health and Opportunity for Me Program established by the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., or its successor program is exempt from §§ 23-99-1120 — 23-99-1126, provided that the Arkansas Health and Opportunity for Me Program, without limiting the Arkansas Health and Opportunity for Me Program's application to any other plan or program, develops and conforms to a program to reduce or eliminate prior authorizations for a healthcare provider ~~on or before January 1, 2025~~.

(3) A qualified health plan that is a health benefit plan under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and purchased on the Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an individual up to four hundred percent (400%) of the federal poverty level,

operating in this state is exempt from §§ 23-99-1120 — 23-99-1126 if the qualified health plan, without limiting the program's application to any other plan or program, develops and conforms to a program to reduce or eliminate prior authorizations for a healthcare provider ~~on or before January 1, 2025~~.

(b)(1)(A) ~~The programs~~ At least one (1) time every two (2) years, a program under subsection (a) of this section to reduce or eliminate prior authorization shall be:

~~(A)~~(i) Submitted to the State Insurance Department; and

~~(B)~~(ii) Subject to approval by the Legislative Council.

(B) A program under subsection (a) of this section shall include:

(i) Data, statistics, and other appropriate documentation demonstrating the effectiveness of the previously submitted program in reducing or eliminating prior authorizations for a healthcare provider; and

(ii) For a program that does not eliminate prior authorizations for a healthcare provider, specific initiatives or elements of the program that reduce existing prior authorizations for a healthcare provider.

(C)(i) Upon submitting the program under subdivision (b)(1) of this section, the submitting entity shall provide notice to each healthcare provider that includes:

(a) The complete program submission;

(b) The deadline for a healthcare provider to comment on the program submission; and

(c) Instructions on how a healthcare provider may comment on the program.

(ii) A healthcare provider shall have at least thirty (30) days to comment on a program submitted under subdivision (b)(1) of this section.

(2) If a program is not submitted to the department and approved by the Legislative Council ~~on or before January 1, 2025~~ as required or does not conform to the requirements of this section, the Medicaid-managed care

program operating in this state, the Arkansas Health and Opportunity for Me Program established by the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., or its successor program, and qualified health plans under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and purchased on the Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an individual up to four hundred percent (400%) of the federal poverty level, operating in this state shall be subject to §§ 23-99-1120 — 23-99-1126 and § 23-99-1128 ~~as of January 1, 2025~~.

(c) Any state or local governmental employee plan is exempt from §§ 23-99-1120 — 23-99-1126 and § 23-99-1128.

(d) A health benefit plan provided by a trust established under §§ 14-54-101 and 25-20-104 to provide benefits, including accident and health benefits, death benefits, dental benefits, and disability income benefits, is exempt from §§ 23-99-1120 — 23-99-1126.

(e)~~(1)~~ Prescription drugs, medicines, biological products, pharmaceuticals, or pharmaceutical services are ~~exempt as a healthcare service for purposes of §§ 23-99-1120 — 23-99-1126 until December 31, 2024~~ subject to the gold card program unless exempted from the gold card program under § 23-99-1128(b).

~~(2)(A) As of January 1, 2025, the provisions of §§ 23-99-1120 — 23-99-1126 shall apply to prescription drugs, medicines, biological products, pharmaceuticals, or pharmaceutical services that have not been approved for continuation of prior authorization under § 23-99-1128.~~

~~(B) For the products in subdivision (e)(2)(A) of this section that have not been approved for continuation of prior authorization, for purposes of § 23-99-1120, then:~~

~~(i) Provisions regarding time periods specified during calendar year 2022 shall instead apply to the same months during calendar year 2023; and~~

~~(ii) Provisions regarding time periods specified during calendar year 2024 shall instead apply to the same months during calendar year 2025.~~

(f)(1) Upon request, a healthcare insurer or a pharmacy benefits manager shall send an eligibility file notification to a healthcare provider.

(2) An eligibility file notification under subdivision (f)(1) of

this section shall indicate whether a subscriber is enrolled in a:

(A) Health benefit plan that is:

(i) Self-insured under the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406;

(ii) A fully insured health benefit plan; or

(iii) A self-funded health benefit plan;

(B) Qualified health benefit plan that is a health benefit plan under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and purchased on the Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an individual up to four hundred percent (400%) of the federal poverty level, operating in this state; or

(C) Qualified health benefit plan that is a health benefit plan under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and purchased as a health benefit plan under Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an individual over four hundred percent (400%) of the federal poverty level.

SECTION 9. Arkansas Code § 23-99-1128 is amended to read as follows:

23-99-1128. Prescription drugs, medicines, biological products, pharmaceuticals, or pharmaceutical services.

(a)~~(1) Beginning on January 1, 2024, a healthcare insurer or pharmacy benefits manager shall submit a written request to the Arkansas State Board of Pharmacy for any prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service to be reviewed for a continuation of prior authorization by a specified health benefit plan whether or not a healthcare provider has met the criteria for an exemption from prior authorization under §§ 23-99-1120 — 23-99-1126.~~

~~(2) The request under subdivision (a)(1) of this section shall state the reason the request is being made for each prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service for the specified health benefit plan~~ If a prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service is not exempt from the gold card program under subsection (b) of this section, then a healthcare provider shall be reviewed by a healthcare insurer or pharmacy

benefits manager under the gold card program for the prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service.

(b)(1) ~~*The Arkansas State Board of Pharmacy and the Arkansas State Medical Board, jointly, may establish criteria and procedures to review whether a request made under subdivision (a)(1) of this section should be granted for the requesting party and specified health benefit plan*~~ *For a prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service to be exempt from the gold card program, a healthcare insurer or pharmacy benefits manager may submit a written request to the Arkansas State Board of Pharmacy for approval.*

(2) A request under subdivision (b)(1) of this section shall state the reason the request is being made for each prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service for which exemption from the gold card program is requested.

(3) The Arkansas State Board of Pharmacy and the Arkansas State Medical Board, jointly, shall establish criteria and procedures to review whether a request for exemption from the gold card program made under subdivision (b)(1) of this section should be granted.

(4) The criteria established under subdivision (b)(3) of this section shall include criteria related to the cost and the safety of the prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service.

(5) Under the criteria established and procedures described under subdivision (b)(3) of this section, the Arkansas State Board of Pharmacy and the Arkansas State Medical Board, jointly, shall determine whether to approve a request to exempt a prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service from the gold card program.

(6) The Arkansas State Board of Pharmacy shall promptly notify the entity that made the request of the joint decision made by the Arkansas State Board of Pharmacy and the Arkansas State Medical Board.

(7) The decision of the Arkansas State Board of Pharmacy and the Arkansas State Medical Board, jointly, regarding each prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service shall apply to all healthcare insurers or pharmacy benefits managers.

(8) The Arkansas State Board of Pharmacy shall post on the

Arkansas State Board of Pharmacy's website a list of prescription drugs, medicines, biological products, pharmaceuticals, or pharmaceutical services that are exempt from the gold card program.

(9) An approval for exemption from the gold card program is valid for two (2) years from the date of the notice provided under subdivision (b)(6) of this section.

~~*(c)(1) The Arkansas State Board of Pharmacy and the Arkansas State Medical Board, jointly, may determine whether or not a prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service may be subject to prior authorization by a health benefit plan under the criteria and procedures under subsection (b) of this section.*~~

~~*(2) The Arkansas State Board of Pharmacy shall promptly notify the entity that made the request of the joint decision made by the Arkansas State Board of Pharmacy and the Arkansas State Medical Board.*~~

~~*(d) The Arkansas State Board of Pharmacy shall make available to any person who requests it, a list for any health benefit plan of prescription drugs, medicines, biological products, pharmaceuticals, or pharmaceutical services that require a prior authorization under this section.*~~

SECTION 10. Arkansas Code § 23-99-1129 is amended to read as follows:

23-99-1129. Appeals process for disallowance of prior authorization.

(a) If the Arkansas State Board of Pharmacy and the Arkansas State Medical Board, jointly, disallow a prior authorization of a prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service requested under § 23-99-1128, a healthcare insurer, pharmacy benefits manager, or other interested party may file an appeal to the State Insurance Department within ninety (90) days of the disallowance of the prior authorization.

(b) The healthcare insurer, pharmacy benefits manager, or other interested party shall provide a notice of seven (7) days to the Arkansas State Board of Pharmacy and the Arkansas State Medical Board of the healthcare insurer's, pharmacy benefits manager's, or other interested party's intent to file an appeal.

(c) No later than the thirtieth day after the date a healthcare insurer, pharmacy benefits manager, or other interested party files an appeal under subsection (a) of this section, the Insurance Commissioner shall

appoint an independent review organization to review the appeal.

~~(c)~~(d) A healthcare insurer, pharmacy benefits manager, or other interested party that files an appeal under subsection (a) of this section shall pay for the independent review organization appointed under subsection ~~(b)~~(c) of this section to review the appeal.

(e)(1) If a healthcare insurer, pharmacy benefits manager, or other interested party succeeds in its appeal and overturns the decision of the Arkansas State Board of Pharmacy and the Arkansas State Medical Board, the healthcare insurer, pharmacy benefits manager, or other interested party shall be reimbursed for fifty percent (50%) of the cost remitted to the independent review organization under subsection (d) of this section.

(2) The Arkansas State Board of Pharmacy and the Arkansas State Medical Board shall each provide twenty-five percent (25%) of the total reimbursement to the healthcare insurer, pharmacy benefits manager, or other interested party under subdivision (e)(1) of this section.

~~(d)~~(f) A healthcare insurer, pharmacy benefits manager, or other interested party is bound by the independent review organization's determination of the appeal under this section.

/s/L. Johnson

APPROVED: 4/10/25