

Stricken language would be deleted from and underlined language would be added to present law.  
Act 575 of the Regular Session

1 State of Arkansas As Engrossed: H3/6/23 H3/9/23 S3/16/23

2 94th General Assembly

**A Bill**

3 Regular Session, 2023

HOUSE BILL 1271

4

5 By: Representatives L. Johnson, Achor, F. Allen, Bentley, Breaux, K. Brown, M. Brown, Joey Carr,  
6 Cavanaugh, Duffield, Ennett, Eubanks, D. Ferguson, V. Flowers, D. Garner, Gramlich, Hawk, G.  
7 Hodges, Hollowell, Ladyman, Long, J. Mayberry, McAlindon, McGrew, B. McKenzie, S. Meeks, J.  
8 Moore, Painter, Pilkington, J. Richardson, R. Scott Richardson, Richmond, Rye, Underwood, Vaught,  
9 Wardlaw, D. Whitaker, Womack, Wooten

10 By: Senators Irvin, J. Boyd

11

12

**For An Act To Be Entitled**

13

AN ACT TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY  
14 ACT; TO EXEMPT CERTAIN HEALTHCARE PROVIDERS THAT  
15 PROVIDE CERTAIN HEALTHCARE SERVICES FROM PRIOR  
16 AUTHORIZATION REQUIREMENTS; AND FOR OTHER PURPOSES.

17

18

19

**Subtitle**

20

TO AMEND THE PRIOR AUTHORIZATION  
21 TRANSPARENCY ACT; AND TO EXEMPT CERTAIN  
22 HEALTHCARE PROVIDERS THAT PROVIDE CERTAIN  
23 HEALTHCARE SERVICES FROM PRIOR  
24 AUTHORIZATION REQUIREMENTS.

25

26

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

28

29 SECTION 1. Arkansas Code § 23-99-1103(8), concerning the definition of  
30 "healthcare insurer" under the Prior Authorization Transparency Act, is  
31 amended to read as follows:

32

(8)(A)(i) "Healthcare insurer" means an entity that is subject  
33 to state insurance regulation, including an insurance company, a health  
34 maintenance organization, a hospital and medical service corporation, a risk-  
35 based provider organization, and a sponsor of a nonfederal self-funded  
36 governmental plan.



1 (ii) "Healthcare insurer" includes Medicaid where  
2 specifically referenced in §§ 23-99-1119 – 23-99-1126.

3 (B) "Healthcare insurer" does not include:

4 (i) A workers' compensation plan;

5 (ii) Medicaid, except as provided under §§ 23-99-  
6 1119 – 23-99-1126 or when Medicaid services are managed or reimbursed by a  
7 healthcare insurer; or

8 (iii) An entity that provides only dental benefits  
9 or eye and vision care benefits;

10  
11 SECTION 2. Arkansas Code § 23-99-1103, concerning definitions used  
12 under the Prior Authorization Transparency Act, is amended to add additional  
13 subdivisions to read as follows:

14 (22) "Random sample" means at least five (5) claims but no more  
15 than twenty (20) claims for a particular healthcare service that are selected  
16 without method or conscious decision; and

17 (23) "Value-based reimbursement" means reimbursement that:

18 (A) Ties a payment for the provision of healthcare  
19 services to the quality of health care provided;

20 (B) Rewards a healthcare provider for efficiency and  
21 effectiveness; and

22 (C) May impose a risk-sharing requirement on a healthcare  
23 provider for healthcare services that do not meet the healthcare insurer's  
24 requirements for quality, effectiveness, and efficiency.

25  
26 SECTION 3. Arkansas Code § 23-99-1104(a)(1), concerning disclosure  
27 required under the Prior Authorization Transparency Act, is amended to read  
28 as follows:

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

32 (B) The disclosure under subdivision (a)(1)(A) of this  
33 section shall include:

34 (i) A list of any healthcare services that require  
35 prior authorization; and

36 (ii) Any written clinical criteria.

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SECTION 4. Arkansas Code § 23-99-1111 is amended to read as follows:

23-99-1111. Requests for prior authorization – Qualified persons authorized to review and approve – Adverse determinations to be made only by Arkansas-licensed physicians – Opportunity to discuss treatment before adverse determination.

(a) The initial review of information submitted in support of a request for prior authorization may be conducted by a qualified person employed or contracted by a utilization review entity.

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

(c)(1) An adverse determination regarding a request for prior authorization shall be made by a physician who possesses a current and unrestricted license to practice medicine in the State of Arkansas issued by the Arkansas State Medical Board.

(2)(A) A utilization review entity shall provide a method by which a physician may request that a prior authorization request be reviewed by a physician in the same specialty as the physician making the request, by a physician in another appropriate specialty, or by a pharmacologist.

(B) If a request is made under subdivision (c)(2)(A) of this section, the reviewing physician or pharmacologist is not required to meet the requirements of subdivision (c)(1) of this section.

(3)(A) Subject to this subdivision (c)(3), when an adverse determination is issued by a utilization review entity that questions the medical necessity, the appropriateness, or the experimental or investigational nature of a healthcare service, the utilization review entity shall provide in the notice of adverse determination the name and telephone number of a physician who possesses a current and unrestricted license in this state with whom the requesting healthcare provider may have a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the intervention.

(B) The requesting healthcare provider may contact the reviewing physician at the telephone number provided with the adverse determination under subdivision (c)(3)(A) of this section within one (1) business day of receipt of the adverse determination for an urgent service, or within two (2) business days of receipt of the adverse determination for a

1 nonurgent service, to engage in the discussion of the patient's treatment  
2 plan and the clinical basis for the intervention under subdivision (c)(3)(A)  
3 of this section.

4 (C)(i) Following any discussion under subdivision  
5 (c)(3)(B) of this section, the utilization review entity shall notify the  
6 healthcare provider whether or not the adverse determination decision remains  
7 the same or the service is approved.

8 (ii) The notice under subdivision (c)(3)(C)(i) of  
9 this section shall be provided:

10 (a) Within one (1) business day of the  
11 discussion under subdivision (c)(3)(B) of this section between the provider  
12 and physician for an urgent service; or

13 (b) Within two (2) business days of the  
14 discussion under subdivision (c)(3)(B) of this section between the provider  
15 and physician for a nonurgent service.

16 (D) A discussion under subdivision (c)(3)(A) of this  
17 section shall not replace or eliminate the opportunity for any internal  
18 grievance or appeal process provided by the utilization review entity.

19 (E) If a requesting healthcare provider is a physician,  
20 then the reviewing physician with whom the requesting physician is given an  
21 opportunity to discuss the treatment plan and clinical basis for the  
22 intervention under subdivision (c)(3)(B) of this section shall be a physician  
23 who:

24 (i) Possesses a current and unrestricted  
25 license to practice medicine in this state; and

26 (ii) Has the same or similar specialty as the  
27 healthcare provider.

28  
29 SECTION 5. Arkansas Code Title 23, Chapter 99, Subchapter 11, is  
30 amended to add additional sections to read as follows:

31 23-99-1120. Initial exemption from prior authorization requirements  
32 for healthcare providers providing certain healthcare services.

33 (a)(1) Except as provided under subdivision (a)(2) of this section,  
34 beginning on and after January 1, 2024, a healthcare provider that received  
35 approval for ninety percent (90%) or more of the healthcare provider's prior  
36 authorization requests based on a review of the healthcare provider's

1 utilization of the particular healthcare services from January 1, 2022,  
2 through June 30, 2022, shall not be required to obtain prior authorization  
3 for a particular healthcare service and shall be considered exempt from prior  
4 authorization requirements through September 30, 2024.

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

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

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

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

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

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

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

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

32 (d) Except as provided under subsection (f) of this section or § 23-  
33 99-1125, a healthcare insurer that uses a prior authorization process for  
34 healthcare services shall not require a healthcare provider to obtain prior  
35 authorization for a particular healthcare service that a healthcare provider  
36 has previously been subject to a prior authorization requirement if, in the

1 most recent six-month evaluation period as described under subsection (e) of  
2 this section, the healthcare insurer has approved or would have approved no  
3 less than ninety percent (90%) of the prior authorization requests submitted  
4 by the healthcare provider for that particular healthcare service.

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

9 (2) The six-month period for the evaluation period described  
10 under subsection (d) of this section shall be any consecutive six (6) month  
11 period during the twelve (12) months following the effective date of the  
12 exemption.

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

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

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

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

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

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

25 (h) A healthcare insurer may extend an exemption under subsection (d)  
26 of this section to a group of healthcare providers under the same tax  
27 identification number if:

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

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

33  
34 23-99-1121. Duration of prior authorization exemption.

35 (a) Unless a prior authorization exemption is continued for a longer  
36 period of time by a healthcare insurer under § 23-99-1120(f), a healthcare

1 provider's exemption from prior authorization requirements under § 23-99-1120  
2 remains in effect until the later of:

3 (1) The thirtieth day after the date the healthcare insurer  
4 notifies the healthcare provider of the healthcare insurer's determination to  
5 rescind the exemption as described under § 23-99-1122, if the healthcare  
6 provider does not appeal the healthcare insurer's determination within thirty  
7 (30) days of notification of the determination;

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

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

14 (b) If a healthcare provider appeals the determination to rescind the  
15 exemption more than thirty (30) days after notification of the determination  
16 and the independent review organization overturns the rescission, the  
17 healthcare provider's exemption is restored the fifth day after the date of  
18 the independent review organization's decision, and the exemption remains in  
19 effect for twelve (12) months after restoration unless rescinded under § 23-  
20 99-1122.

21 (c) If a healthcare insurer does not finalize a rescission  
22 determination as specified in subsection (a) of this section, then the  
23 healthcare provider is considered to have met the criteria under § 23-99-1120  
24 to continue to qualify for the exemption.

25 (d) A healthcare provider shall not rely on another healthcare  
26 provider's exemption except when the healthcare provider with an exemption is  
27 the healthcare provider that orders healthcare services that are rendered by  
28 a healthcare provider without an exemption.

29  
30 23-99-1122. Denial or rescission of prior authorization exemption.

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

34 (1) The healthcare insurer makes a determination that, on the  
35 basis of a retrospective review of a random sample of claims selected by the  
36 healthcare insurer during the most recent evaluation period described by §

1 23-99-1120(e), less than ninety percent (90%) of the claims for the  
2 particular healthcare service met the medical necessity criteria that would  
3 have been used by the healthcare insurer when conducting prior authorization  
4 review for the particular healthcare service during the relevant evaluation  
5 period;

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

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

10 (B) Providing:

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

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

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

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

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

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

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

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



1 criteria;

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

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

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

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

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

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

18 (v) An instruction to the healthcare provider to  
19 return the form to the healthcare insurer before the date the rescission  
20 becomes effective; and

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

24 (b) A determination made under subdivision (a)(1) of this section  
25 shall be made by a physician who:

26 (1) Possesses a current and unrestricted license to practice  
27 medicine in this state; and

28 (2) Has the same or similar specialty as the healthcare  
29 provider.

30 (c)(1) A healthcare insurer that is conducting an evaluation under  
31 subsection (a) of this section to determine whether or not a healthcare  
32 provider still qualifies for a prior authorization exemption may request  
33 medical records and documents required for the retrospective review, limited  
34 to no more than twenty (20) claims for a particular healthcare service.

35 (2) A healthcare insurer shall provide a healthcare provider at  
36 least thirty (30) days to provide the medical records requested under

1 subdivision (c)(1) of this section.

2 (d) A healthcare insurer may deny an exemption from prior  
3 authorization requirements under § 23-99-1120 only if:

4 (1) The healthcare provider does not have an exemption at the  
5 time of the relevant evaluation period; and

6 (2) The healthcare insurer provides the healthcare provider  
7 with:

8 (A) Actual data for the relevant prior authorization  
9 request evaluation period; and

10 (B) Detailed information sufficient to demonstrate that  
11 the healthcare provider does not meet the criteria for an exemption from  
12 prior authorization requirements for the particular healthcare service under  
13 § 23-99-1120.

14 (e) A healthcare insurer shall:

15 (1) Allow a healthcare provider to designate an email address or  
16 a mailing address for communications regarding exemptions, denials, and  
17 rescissions;

18 (2) Provide an option for a healthcare provider to submit a  
19 request for an appeal by mail, by email, or by other electronic method; and

20 (3) Include an explanation of how a healthcare provider may  
21 update his or her preferred contact information and delivery method on the  
22 healthcare insurer's website and for all communications issued under this  
23 section.

24  
25 23-99-1123. Independent review of exemption determination.

26 (a)(1) A healthcare provider has a right to a review of an adverse  
27 determination regarding a prior authorization exemption within twelve (12)  
28 months of receiving proper notice of rescission from a healthcare insurer to  
29 be conducted by an independent review organization.

30 (2) A healthcare insurer shall not require a healthcare provider  
31 to engage in an internal appeal process before requesting a review by an  
32 independent review organization under this section.

33 (3) A healthcare provider who has an exemption rescinded due to  
34 a failure to provide medical records within sixty (60) days of a record  
35 request for a retrospective review shall not be eligible for review of that  
36 rescission by an independent review entity.

1 (b) A healthcare insurer shall pay:

2 (1) For any appeal or independent review of an adverse  
3 determination regarding a prior authorization exemption requested under this  
4 section; and

5 (2) A reasonable fee determined by the Arkansas State Medical  
6 Board for any copies of medical records or other documents requested from a  
7 healthcare provider during an exemption rescission review requested under  
8 this section.

9 (c) An independent review organization shall complete an expedited  
10 review of an adverse determination regarding a prior authorization exemption  
11 no later than the thirtieth day after the date a healthcare provider files  
12 the request for a review under this section.

13 (d)(1) A healthcare provider may request that the independent review  
14 organization consider another random sample of no fewer than five (5) and no  
15 more than twenty (20) claims submitted to the healthcare insurer by the  
16 healthcare provider during the relevant evaluation period for the relevant  
17 healthcare service as part of the review under this section.

18 (2) If a healthcare provider makes a request under subdivision  
19 (d)(1) of this section, the independent review organization shall base its  
20 determination on the medical necessity of claims reviewed:

21 (A) By the healthcare insurer under § 23-99-1122; and

22 (B) By the independent review organization under  
23 subdivision (d)(1) of this section.

24 (e) The Insurance Commissioner may refuse, suspend, revoke, or not  
25 renew a license or certificate of authority of a healthcare insurer that has  
26 fifty percent (50%) of healthcare provider appeals overturned in a twelve-  
27 month period by an independent review organization under this section.

28  
29 23-99-1124. Effect of appeal of independent review organization  
30 determination.

31 (a) A healthcare insurer is bound by an appeal or independent review  
32 organization determination that does not affirm the determination made by the  
33 healthcare insurer to rescind a prior authorization exemption.

34 (b) A healthcare insurer shall not retroactively deny a healthcare  
35 service on the basis of a rescission of an exemption, even if the healthcare  
36 insurer's determination to rescind the prior authorization exemption is

1 affirmed by an independent review organization.

2 (c) If a determination of a prior authorization exemption made by the  
3 healthcare insurer is overturned on review by an independent review  
4 organization, the healthcare insurer:

5 (1) Shall not attempt to rescind the exemption before the end of  
6 the next evaluation period; and

7 (2) May only rescind the exemption if the healthcare insurer  
8 complies with §§ 23-99-1122 and 23-99-1123.

9  
10 23-99-1125. Eligibility for prior authorization exemption following  
11 finalized exemption rescission or denial.

12 (a) After a final determination or review affirming the rescission or  
13 denial of an exemption for a specific healthcare service under § 23-99-1120,  
14 a healthcare insurer shall conduct another evaluation to determine whether or  
15 not the exemption should be granted or reinstated based on the six-month  
16 evaluation period that follows the evaluation period that formed the basis of  
17 the rescission or denial of an exemption.

18 (b) A time period that is included in a previous evaluation or  
19 determination period shall not be included in a subsequent evaluation period.

20  
21 23-99-1126. Effect of prior authorization exemption.

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

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

33 (2) Substantially failed to perform the healthcare service.

34 (b) A healthcare insurer shall not conduct a retrospective review of a  
35 healthcare service subject to an exemption except:

36 (1) To determine if the healthcare provider still qualifies for

1 an exemption under § 23-99-1120; or

2 (2) If the healthcare insurer has a reasonable cause to suspect  
3 a basis for denial exists under subsection (a) of this section.

4 (c) For a retrospective review described by subdivision (b)(2) of this  
5 section, §§ 23-99-1120 – 23-99-1125 shall not modify or otherwise affect:

6 (1) The requirements under or application of § 23-99-1115,  
7 including without limitation any time frames; or

8 (2) Any other applicable law, except to prescribe the only  
9 circumstances under which:

10 (A) A retrospective review may occur as specified by  
11 subdivision (b)(2) of this section; or

12 (B) Payment may be denied or reduced as specified by  
13 subsection (a) of this section.

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

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

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

20 (3) Statement of the duration of the exemption.

21 (e) If a healthcare provider submits a prior authorization request for  
22 a healthcare service for which the healthcare provider has an exemption from  
23 prior authorization requirements under § 23-99-1120, the healthcare insurer  
24 shall promptly provide a notice to the healthcare provider that includes:

25 (1) The information described in subsection (d) of this section;  
26 and

27 (2) A notification of the healthcare insurer's payment  
28 requirements.

29 (f) This section and §§ 23-99-1120 – 23-99-1125 shall not be construed  
30 to:

31 (1) Authorize a healthcare provider to provide a healthcare  
32 service outside the scope of the healthcare provider's applicable license; or

33 (2) Require a healthcare insurer to pay for a healthcare service  
34 described by subdivision (f)(1) of this section that is performed in  
35 violation of the laws of this state.

36 (g) A healthcare insurer that offers multiple health benefit plans or

1 that utilizes multiple healthcare provider networks shall not determine a  
2 healthcare provider's eligibility for an exemption from prior authorization  
3 for each specific health benefit plan or each specific healthcare provider  
4 network but rather shall determine the healthcare provider's eligibility for  
5 an exemption applicable to all health benefit plans and healthcare provider  
6 networks.

7 (h) If a healthcare insurer and a healthcare provider are engaged in a  
8 value-based reimbursement arrangement for particular healthcare services or  
9 subscribers, the healthcare insurer shall not impose any prior authorization  
10 requirements for any particular healthcare service that is included in that  
11 value-based reimbursement arrangement.

12  
13 23-99-1127. Applicability.

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

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

28 (3) A qualified health plan that is a health benefit plan under  
29 the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and  
30 purchased on the Arkansas Health Insurance Marketplace created under the  
31 Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an  
32 individual up to four hundred percent (400%) of the federal poverty level,  
33 operating in this state is exempt from §§ 23-99-1120 – 23-99-1126 if the  
34 qualified health plan, without limiting the program's application to any  
35 other plan or program, develops a program to reduce or eliminate prior  
36 authorizations for a healthcare provider on or before January 1, 2025.

1 (b)(1) The programs under subsection (a) of this section to reduce or  
2 eliminate prior authorization shall be:

3 (A) Submitted to the State Insurance Department; and

4 (B) Subject to approval by the Legislative Council.

5 (2) If a program is not submitted to the department and approved  
6 by the Legislative Council on or before January 1, 2025, the Medicaid-managed  
7 care program operating in this state, the Arkansas Health and Opportunity for  
8 Me Program established by the Arkansas Health and Opportunity for Me Act of  
9 2021, § 23-61-1001 et seq., or its successor program, and qualified health  
10 plans under the Patient Protection and Affordable Care Act, Pub. L. No. 111-  
11 148, and purchased on the Arkansas Health Insurance Marketplace created under  
12 the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an  
13 individual up to four hundred percent (400%) of the federal poverty level,  
14 operating in this state shall be subject to §§ 23-99-1120 – 23-99-1126 and §  
15 23-99-1128 as of January 1, 2025.

16 (c) Any state or local governmental employee plan is exempt from §§  
17 23-99-1120 – 23-99-1126 and § 23-99-1128.

18 (d) A health benefit plan provided by a trust established under §§ 14-  
19 54-101 and 25-20-104 to provide benefits, including accident and health  
20 benefits, death benefits, dental benefits, and disability income benefits, is  
21 exempt from §§ 23-99-1120 – 23-99-1126.

22 (e)(1) Prescription drugs, medicines, biological products,  
23 pharmaceuticals, or pharmaceutical services are exempt as a healthcare  
24 service for purposes of §§ 23-99-1120 – 23-99-1126 until December 31, 2024.

25 (2)(A) As of January 1, 2025, the provisions of §§ 23-99-1120 –  
26 23-99-1126 shall apply to prescription drugs, medicines, biological products,  
27 pharmaceuticals, or pharmaceutical services that have not been approved for  
28 continuation of prior authorization under § 23-99-1128.

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

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

35 (ii) Provisions regarding time periods specified  
36 during the calendar year 2024 shall instead apply to the same months during

1 calendar year 2025.

2  
3 23-99-1128. Prescription drugs, medicines, biological products,  
4 pharmaceuticals, or pharmaceutical services.

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

12 (2) The request under subdivision (a)(1) of this section shall  
13 state the reason the request is being made for each prescription drug,  
14 medicine, biological product, pharmaceutical, or pharmaceutical service for  
15 the specified health benefit plan.

16 (b) The Arkansas State Board of Pharmacy and the Arkansas State  
17 Medical Board, jointly, may establish criteria and procedures to review  
18 whether a request made under subdivision (a)(1) of this section should be  
19 granted for the requesting party and specified health benefit plan.

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

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

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

32  
33 23-99-1129. Appeals process for disallowance of prior authorization.

34 (a) If the Arkansas State Board of Pharmacy and the Arkansas State  
35 Medical Board, jointly, disallow a prior authorization of a prescription  
36 drug, medicine, biological product, pharmaceutical, or pharmaceutical service



1 requested under § 23-99-1128, a healthcare insurer, pharmacy benefits  
2 manager, or other interested party may file an appeal to the State Insurance  
3 Department within ninety (90) days of the disallowance of the prior  
4 authorization.

5 (b) No later than the thirtieth day after the date a healthcare  
6 insurer, pharmacy benefits manager, or other interested party files an appeal  
7 under subsection (a) of this section, the Insurance Commissioner shall  
8 appoint an independent review organization to review the appeal.

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

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

16  
17 /s/L. Johnson  
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20 **APPROVED: 4/11/23**  
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