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2 95th General Assembly

A Bill

3 Regular Session, 2025

HOUSE BILL 1300

4

5 By: Representative L. Johnson

6 By: Senator Irvin

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For An Act To Be Entitled

9 AN ACT TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY
10 ACT; TO MODIFY THE DEFINITION OF "PRIOR
11 AUTHORIZATION" UNDER THE PRIOR AUTHORIZATION
12 TRANSPARENCY ACT; TO CLARIFY DISCLOSURE REQUIREMENTS;
13 TO REQUIRE ADDITIONAL DISCLOSURES BY A UTILIZATION
14 REVIEW ENTITY UNDER THE PRIOR AUTHORIZATION
15 TRANSPARENCY ACT; TO EXEMPT CERTAIN HEALTHCARE
16 SERVICES FROM PRIOR AUTHORIZATION; TO CLARIFY THE
17 DURATION OF APPROVED PRIOR AUTHORIZATION REQUESTS; TO
18 CREATE A PROCESS FOR REVIEW OR APPROVAL OF A
19 HEALTHCARE SERVICE UPON FAILURE OF A UTILIZATION
20 REVIEW ENTITY TO COMPLY WITH THE PRIOR AUTHORIZATION
21 TRANSPARENCY ACT; AND FOR OTHER PURPOSES.

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Subtitle

25 TO AMEND THE PRIOR AUTHORIZATION
26 TRANSPARENCY ACT.

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

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

32 19-5-1161. Prior Authorization Transparency Act Trust Fund.

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

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



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

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

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

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

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

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

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

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

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

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

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

27 (B) "Healthcare service" includes without limitation the
28 provision of pharmaceutical products or services or durable medical equipment
29 that is identifiable by:

30 (i) The Current Procedural Terminology code;

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

33 (iii) The National Drug Code;
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35 SECTION 3. Arkansas Code § 23-99-1103(15), concerning the definition
36 of "prior authorization" under the Prior Authorization Transparency Act, is

1 amended to read as follows:

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

11 (B) "Prior authorization" ~~may include, unless otherwise~~
 12 ~~provided under this subchapter or otherwise inapplicable, includes without~~
 13 limitation:

14 (i) Preadmission review;

15 (ii) Pretreatment review;

16 (iii) Precertification;

17 (iv) Predetermination;

18 (v) Prospective utilization review;

19 (vi) Concurrent review;

20 (vii) Fail first protocols;

21 (viii) Medical necessity determination;

22 (ix) Prior notification; and

23 (x) ~~the~~ The requirement that a subscriber or
 24 healthcare provider notify the health insurer or utilization review entity of
 25 the subscriber's intent to receive a healthcare service before the healthcare
 26 service is provided;

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

29 23-99-1104. Disclosure required.

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

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

36 (i)(a) A list of any healthcare services that

1 require prior authorization.

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

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

7 (2) Include the following information:

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

10 (B)(i) The effective date and end
11 date of the prior authorization requirement policy for the healthcare
12 service.

13 (ii) A healthcare service that no longer requires a
14 prior authorization shall remain on the list for two (2);

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

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

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

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

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

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

1 (i) Providing the healthcare provider with temporary
2 electronic access in a timely manner to a secure site to review copyright-
3 protected clinical criteria; or

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

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

12 (c)(1) Before implementing a new or amended prior authorization
13 requirement, clinical criteria, or restriction, a utilization review entity
14 shall provide contracted healthcare providers written notice of the new or
15 amended requirement or restriction at least sixty (60) days before
16 implementation of the new or amended requirement or restriction.

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

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

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

25 (A) Physician specialty;

26 (B) Medication or diagnostic test or procedure;

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

29 (D) Reason for denial.

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

34 (e)(1) If a utilization review entity provides information to a
35 healthcare provider indicating that a prior authorization is not required for
36 a specific healthcare service, then the utilization review entity shall

1 disclose any other restriction, limitation, or requirement that may preclude
2 coverage of the specific healthcare service, including without limitation:

3 (A) A step therapy requirement;

4 (B) A restriction on the place of the specific healthcare
5 service;

6 (C) A restriction on the healthcare provider type or benefit
7 category;

8 (D) Clinical criteria that completely excludes the specific
9 healthcare service from coverage; and

10 (E) Any post-service review, information request, or audit
11 responsibility that is applicable to the specific healthcare service based on
12 the billing code or category.

13 (2)(A) Subdivision (e)(1) of this section does not apply if a
14 utilization review entity provides a document on the utilization review
15 entity's website or in a format available to download from the utilization
16 review entity's website that includes the following information in an
17 aggregated format:

18 (i) A list of step therapy requirements;

19 (ii) A list of any restrictions on the site of
20 service for a specific healthcare service, to the extent that the restriction
21 deviates from the requirements under Medicare;

22 (iii) A list of any restrictions to the benefit
23 category of a specific healthcare service, to the extent that the restriction
24 deviates from the requirements under Medicare;

25 (iv) A list of any specific healthcare services that
26 are completely excluded from coverage based on clinical criteria; and

27 (v) A list of any specific healthcare services for
28 which the billing code or category requires a post-service review,
29 information request, or audit.

30 (B) The document under subdivision (e)(2)(A) of this
31 section shall include the name of the healthcare service and any billing
32 codes associated with the healthcare service.

33 (C) A utilization review entity shall provide a contracted
34 healthcare provider written notice of any changes to the document under
35 subdivision (e)(2)(A) of this section at least sixty (60) days before
36 implementation of the change via mail, email, or fax.

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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*; or;

(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 authorization was granted more than ninety (90) days before the authorized healthcare service is provided.~~

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)(1) A healthcare insurer shall pay a claim for a healthcare service under the medical benefit of a health benefit plan in the absence of a prior authorization if:

(A) At the time the healthcare service was provided, the patient

1 had been covered by a health benefit plan for sixty (60) days or less; and

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

4 (2) Subdivision (f)(1) of this section does not apply to a
 5 healthcare service provided under the pharmacy benefit of a health benefit
 6 plan.

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

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

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

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

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

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

22 (C) If the period indicated under subdivision
 23 (b)(2)(A)(ii) of this section exceeds one (1) year, a utilization review
 24 entity may limit the duration of a prior authorization to one (1) year.

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

27 23-99-1116. Failure to comply with subchapter – ~~Requested healthcare~~
 28 ~~services deemed approved~~ Enforcement – Fines.

29 (a)(1) ~~If~~ For any provision of this subchapter that relates to a
 30 specific request from a healthcare provider for a prior authorization, if a
 31 healthcare insurer or utilization review entity fails to comply with this
 32 subchapter, the requested healthcare services shall be deemed authorized or
 33 approved.

34 Within two (2) days after a healthcare provider provides notice
 35 that the healthcare insurer or utilization review entity has failed to comply
 36 with this subchapter, the healthcare insurer or utilization

1 review entity shall:

2 (A) Issue the authorization for the requested healthcare
3 service;

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

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

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

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

19 (a) Issue the authorization for the requested
20 healthcare service;

21 (b) Pay the costs of a hearing; and

22 (c)(1) Pay a monetary penalty as described in
23 § 23-66-210(a)(1) of not more than one thousand dollars (\$1,000) for each
24 violation, not to exceed an aggregate penalty of ten thousand dollars
25 (\$10,000), unless the person knew or reasonably should have known he or she
26 was in violation of this subchapter.

27 (2) If a person knew or reasonably
28 should have known he or she was in violation of this subchapter, the penalty
29 under subdivision (c)(1) of this section shall not be more than five thousand
30 dollars (\$5,000) for each violation, not to exceed an aggregate penalty
31 amount of fifty thousand dollars (\$50,000) in any six-month period.

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

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

1 (b) The requesting healthcare provider.

2 (b) A healthcare service that is authorized or approved under
3 subsection (a) of this section is not subject to audit recoupment under § 23-
4 63-1801 et seq.

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

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

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

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

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

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

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

31 (b) Pay a civil fine not to exceed five thousand
32 dollars (\$5,000) per day of noncompliance up to one hundred thousand dollars
33 (\$100,000).

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

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

3 (ii) The requesting healthcare provider.

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

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

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

12 (1) Upon request, a healthcare insurer or a pharmacy benefits
13 manager shall send additional information from the healthcare provider in
14 compliance with this subchapter; and

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

17 (g) If the commissioner imposes a fine under this subchapter, the
18 commissioner shall not impose an additional fine for the same underlying act
19 or omission under any other provision of state law.

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21 /s/L. Johnson
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