State of Arkansas *As Engrossed: S3/4/25*
95th General Assembly **A Bill**
Regular Session, 2025 SENATE BILL 83

By: Senator J. Bryant
By: Representative K. Moore

For An Act To Be Entitled

AN ACT TO MANDATE COVERAGE FOR BREAST RECONSTRUCTION SURGERIES; TO REQUIRE PRIOR AUTHORIZATION FOR BREAST RECONSTRUCTION SURGERIES; TO ESTABLISH A MINIMUM REIMBURSEMENT RATE FOR BREAST RECONSTRUCTION SURGERIES; AND FOR OTHER PURPOSES.

Subtitle

TO MANDATE COVERAGE FOR BREAST RECONSTRUCTION SURGERIES; TO REQUIRE PRIOR AUTHORIZATION FOR BREAST RECONSTRUCTION SURGERIES; AND TO ESTABLISH A MINIMUM REIMBURSEMENT RATE FOR BREAST RECONSTRUCTION SURGERIES.

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

SECTION 1. Arkansas Code Title 23, Chapter 79, is amended to add an additional subchapter to read as follows:

Subchapter 29 — Coverage for Breast Reconstruction Surgery

23-79-2901. Definitions.

As used in this subchapter:

(1) "Ambulatory surgery center" means an entity certified by:

(A) Medicare as an ambulatory surgical center that operates for the purpose of providing surgical services to patients and that is eligible to receive reimbursement from Medicaid for ambulatory surgery

services;

(B) The Joint Commission, an entity for the accreditation of healthcare organizations;

(C) The Accreditation Association for Ambulatory Health Care; or

(D) The American Association for Accreditation of Ambulatory Surgery Facilities;

(2)(A) "Breast reconstruction surgery" means all stages of surgery to repair physical defects caused by the extirpation or medical treatment of diseased breast tissue and all stages of surgery to reconstruct a breast mound or to create a new breast mound and to reestablish symmetry between two (2) breasts:

(i) Following:

(a) Trauma;

(b) The loss of breast tissue due to congenital or noncongenital diseases; or

(c) A mastectomy; or

(ii) For prophylaxis against a future disease of the breast.

(B) "Breast reconstruction surgery" includes without limitation:

(i) Augmentation, reduction, and mastectomy and all procedures for a contralateral breast necessary for symmetry;

(ii) All breast reconstruction modalities, including without limitation implant-based breast reconstruction, tissue-based breast reconstruction, and any breast reconstruction modalities that are developed subsequent to the effective date of this act that are recognized within Level I of the Healthcare Common Procedure Coding System codes and are determined by rule of the Insurance Commissioner to qualify under this subchapter;

(iii) All types of breast reconstruction contained within the modalities under subdivision (2)(B)(ii) of this section, including without limitation:

(a) Immediate implant-based breast reconstruction;

(b) Delayed implant-based breast reconstruction;

(c) Myocutaneous flap tissue-based breast reconstruction;

(d) Microvascular free flap tissue-based breast reconstruction;

(e) Structural fat grafting tissue-based breast reconstruction;

(f) Combined implant-based and tissue-based breast reconstruction; and

(g) Any type of breast reconstruction that is developed subsequent to the effective date of this act that is recognized within Level I of the Healthcare Common Procedure Coding System codes and is determined by rule of the commissioner to qualify under this subchapter;

(iv) All procedural variations, iterations, or approaches associated with the breast reconstruction types under subdivision (2)(B)(iii) of this section, as noted within the short descriptor or the description for the Level I Healthcare Common Procedure Coding System code covering the modalities and types of breast reconstruction;

(v) Chest wall reconstruction, including without limitation an aesthetic flat closure;

(vi) Custom fabricated breast prostheses, including without limitation replacement of such breast prostheses; and

(vii) Coverage for the mechanical, medical, and surgical treatment of physical complications of a mastectomy, breast reconstruction surgery, chest wall reconstruction, radiation, and lymph node surgery;

(3) "Enrollee" means an individual entitled to coverage of healthcare services from a healthcare insurer;

(4) "Facility reimbursement rate" means the amount paid to a healthcare facility by a healthcare insurer for certain procedures and includes the costs of healthcare services;

(5)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued, renewed, or extended in this state by a healthcare insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program and 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.

(B) "Health benefit plan" includes:

(i) Indemnity and managed care plans; and

(ii) Plans providing health benefits to state and public school employees under § 21-5-401 et seq.

(C) "Health benefit plan" does not include:

(i) A plan that provides only dental benefits or eye and vision care benefits;

(ii) A disability income plan;

(iii) A credit insurance plan;

(iv) Insurance coverage issued as a supplement to liability insurance;

(v) Medical payments under an automobile or homeowners insurance plan;

(vi) A health benefit plan provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(vii) A plan that provides only indemnity for hospital confinement;

(viii) An accident-only plan;

(ix) A specified disease plan other than a cancer insurance plan or cancer supplemental policy; or

(x) A long-term-care-only plan;

(6) "Healthcare facility" means:

(A) An ambulatory surgery center;

(B) A hospital; or

(C) An outpatient surgery center;

(7)(A) "Healthcare insurer" means any insurance company, hospital and medical service corporation, health maintenance organization, or a nonprofit agricultural membership organization as defined under § 23-60-104 that issues or delivers health benefit plans in this state.

(B) "Healthcare insurer" does not include an entity that

provides only dental benefits or eye and vision care benefits;

(8) "Healthcare professional" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession;

(9) "Healthcare professional reimbursement rate" means the amount paid to a healthcare professional by a healthcare insurer for procedures and includes the costs of healthcare services;

(10) "Healthcare service" means an item or service provided to an individual for the purposes of alleviating, curing, healing, or preventing human illness, injury, or physical disability;

(11) "Hospital" means a facility licensed as a hospital by the Division of Health Facility Services under § 20-9-213;

(12) "Mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a healthcare professional;

(13) "Out-of-network provider" means a healthcare professional that provides healthcare services to an enrollee but is not a participating provider;

(14)(A) "Outpatient surgery center" means a facility in which surgical services are offered that require the use of general or intravenous anesthetics, and where, in the opinion of the attending physician, hospitalization, as defined in the present licensure law, is not necessary.

(B) "Outpatient surgery center" does not include:

(i) A medical office owned and operated by a physician or more than one (1) physician licensed by the Arkansas State Medical Board, if the medical office does not bill a facility fee to a third-party payor; or

(ii) A dental office that has a Moderate Sedation Facility Permit or a Deep Sedation-General Anesthesia Facility Permit issued by the Arkansas State Board of Dental Examiners; and

(15) "Participating provider" means a healthcare professional that has a healthcare contract with a contracting entity to provide healthcare services to an enrollee with the expectation of receiving payment either directly from the contracting entity or from a healthcare insurer affiliated with the contracting entity.

23-79-2902. Coverage for breast reconstruction surgery.

(a) On and after January 1, 2026, a health benefit plan that is offered, issued, or renewed in this state shall provide coverage for all modalities, types, and techniques of a healthcare service provided for a breast reconstruction surgery and shall cover any surgery determined as the best course of treatment by a healthcare professional, consistent with prevailing medical standards, and in consultation with the patient.

(b) The coverage for breast reconstruction surgery under this section:

(1) Shall be subject to policy *deductibles, copayment requirements, or coinsurance* requirements of a healthcare insurer at a cost that is no more than those costs associated with the health benefit plan's in-network rate for the healthcare service;

(2) Does not diminish or limit benefits otherwise allowable under a health benefit plan; and

(3) Shall not affect an enrollee's eligibility or continued eligibility to enroll or renew coverage under the terms of the health benefit *plan solely for the purpose of avoiding the requirements of this subchapter.*

(c) If an enrollee is forced to use an out-of-network provider due to a healthcare insurer's network inadequacy, the enrollee's financial responsibility shall remain at an in-network rate.

23-79-2903. Prior authorization required for breast reconstruction surgery — Single case agreements.

(a) A healthcare insurer shall require prior authorization for breast reconstruction surgery.

(b) If a healthcare insurer does not have a participating provider who provides a breast reconstruction surgery that has been determined as the best course of treatment by a healthcare professional and is consistent with prevailing medical standards and in consultation with the patient, then the healthcare insurer that provides a prior authorization or predetermination of the healthcare service shall automatically approve a single case agreement at the same rate as a participating provider for the out-of-network provider.

23-79-2904. Reimbursement rate — Penalties for late payment or nonpayment.

(a) If a healthcare insurer does not have a participating provider who provides a breast reconstruction surgery that has been determined as the best

course of treatment by a healthcare professional and is consistent with prevailing medical standards and in consultation with the patient, then the healthcare insurer shall reimburse the out-of-network provider who performs the breast reconstruction surgery at an amount that is the lesser of:

(1) The healthcare professional's billed charges for the healthcare services; or

(2) The eightieth percentile of all charges for the particular healthcare service performed by a healthcare professional in the same or similar specialty and provided in the same or similar geographical area as reported in a benchmarking database that is maintained by a nonprofit organization if that nonprofit organization is not affiliated with, financially supported by, or otherwise supported by a healthcare insurer.

(b) A healthcare insurer shall provide a fair and reasonable facility reimbursement rate for healthcare services performed by a healthcare *professional in a healthcare facility under this subchapter.*

(c)(1) In the case of a healthcare insurer that does not reimburse an out-of-network provider or a healthcare facility as required under this section, the healthcare insurer, in addition to making the required payment for the healthcare services, shall pay the out-of-network provider or healthcare facility an amount that is three (3) times the difference between:

(A) The initial payment, or in the case of a notice of denial of payment, zero dollars ($0.00); and

(B) The out-of-network reimbursement rate required under this section, less any cost-sharing required to be paid by the enrollee.

(2) The payment that is required under subdivision (c)(1) of this section is subject to interest in a manner specified by the Insurance Commissioner by rule.

23-79-2905. Coverage eligibility.

A healthcare insurer providing benefits under this subchapter shall not deny an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the health benefit plan solely for the purpose of avoiding the requirements of this subchapter.

23-79-2906. Waiver prohibited.

(a) The provisions of this subchapter shall not be waived by contract.

(b) A contractual arrangement or action taken in conflict with this subchapter or that purport to waive any requirement of this subchapter is *void.*

(c) This subchapter shall not be used by a healthcare insurer to lower reimbursement rates for other healthcare services involving breast reconstruction provided by a participating provider.

23-79-2907. Rules.

(a) The Insurance Commissioner *shall develop* and promulgate rules for the implementation and administration of this subchapter.

(b) The State Board of Finance *shall develop* and promulgate rules for the administration of this subchapter for the plans providing health benefits to state and public school employees under § 21-5-401 et seq.

/s/J. Bryant