Stricken language would be deleted from and underlined language would be added to present law.

State of Arkansas *As Engrossed: H3/8/23 H3/16/23*
94th General Assembly **A Bill**
Regular Session, 2023 HOUSE BILL 1274

By: Representative L. Johnson
By: Senator Irvin

For An Act To Be Entitled

AN ACT TO MODIFY THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO AMEND THE APPEAL PROCESS FOR A DENIAL UNDER THE PRIOR AUTHORIZATION TRANSPARENCY ACT; AND FOR OTHER PURPOSES.

Subtitle

TO MODIFY THE PRIOR AUTHORIZATION TRANSPARENCY ACT; AND TO AMEND THE APPEAL PROCESS FOR A DENIAL UNDER THE PRIOR AUTHORIZATION TRANSPARENCY ACT.

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

SECTION 1. Arkansas Code § 23-99-1103(21), concerning the definition of "utilization review entity" used under the Prior Authorization Transparency Act, is amended to add an additional subdivision to read as follows:

(D) A third-party administrator of a self-insured healthcare insurer is a utilization review entity if it performs prior authorizations.

SECTION 2. Arkansas Code § 23-99-1105, concerning nonurgent healthcare service under the Prior Authorization Transparency Act, is amended to add an additional subsection to read as follows:

(c)(1) If a utilization review entity denies a prior authorization of a nonurgent healthcare service, then the subscriber or the healthcare

provider may elect to appeal the denial of the prior authorization of the nonurgent healthcare service.

(2) If a denial of a prior authorization of a nonurgent healthcare service is appealed to the utilization review entity, then within *four (4) business days* of receiving all necessary information required, the utilization review entity shall:

(A) Make an authorization or adverse determination; and

(B) Notify the subscriber and the healthcare provider that appealed the denial of the prior authorization of the nonurgent healthcare service of the decision.

(3) This subsection applies to an enrollee who is being evaluated or treated for:

(A) A hematology diagnosis;

(B) An oncology diagnosis; or

(C) An additional disease state or other diagnoses that the Insurance Commissioner may include by rule.

SECTION 3. Arkansas Code § 23-99-1106 is amended to read as follows:

23-99-1106. Prior authorization — Urgent healthcare service.

(a) A utilization review entity shall render an expedited authorization or adverse determination concerning an urgent healthcare service and notify the subscriber and the subscriber's healthcare provider of that expedited prior authorization or adverse determination no later than one (1) business day after receiving all information needed to complete the review of the requested urgent healthcare service.

(b)(1) If a utilization review entity denies a prior authorization of an urgent healthcare service, then the subscriber or the healthcare provider may elect to appeal the denial of the prior authorization of the urgent healthcare service.

(2) If a denial of a prior authorization of an urgent healthcare service is appealed to the utilization review entity, then within *two (2) business days of* receiving all necessary information required, the utilization review entity shall:

(A) Make an authorization or adverse determination; and

(B) Notify the subscriber and the healthcare provider that appealed the denial of the prior authorization of the urgent healthcare

service of the decision.

(3) This subsection applies to an enrollee who is being evaluated or treated for:

(A) A hematology diagnosis;

(B) An oncology diagnosis; or

(C) An additional disease state or other diagnoses that the Insurance Commissioner may include by rule.

SECTION 4. Arkansas Code § 23-99-1114, concerning the limitation on step therapy under the Prior Authorization Transparency Act, is amended to add an additional subsection to read as follows:

(c) If a request for prior authorization is denied due to a step therapy requirement under this section, then the utilization review entity shall authorize the preferred treatment required under the step therapy if a prior authorization for the preferred treatment is required without requiring the healthcare provider to submit a new or revised request.

/s/L. Johnson