Arkansas Setting the Pace on Prior Authorization Transparency

ACT 815 OF 2017
AMENDMENTS TO THE PRIOR AUTHORIZATION TRANSPARENCY ACT

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Arkansas Act 815 of 2017

- Sponsored by Senator Missy Irvin.

- Builds on previous work by Arkansas Medical Society, Senator Irvin and other supporters in the legislature to address physician complaints over lack of transparency and administrative burden in prior authorization processes.
Expands the definition of medical necessity to include any terminology a healthcare insurer may use to describe a determination based on clinical justification for a healthcare service.

Adds to the definition of emergency healthcare services, which do not require prior authorization, a surgical procedure to correct a condition discovered during surgery for an already diagnosed condition—avoids the need for a second operation.
Disclosure of review criteria required

- But allows utilization review entities or healthcare insurers that use proprietary clinical criteria for prior authorization to limit the availability of those criteria to healthcare providers via a link from the public part of their website.
Turnaround times

- 23-99-1105 (existing law)
  PA Non-urgent – 2 business days

- 23-99-1106 (existing law)
  PA Urgent – 1 business day

- 23-99-1107 (existing law)
  Emergency – min 24 hours following procedure

- 23-99-1117 -- Prescription drugs – 72 hours
23-99-1108
Terminal illness/ Pain medications

- Incorporates previously uncodified provisions of 2015 law to prohibit denial of prior authorization for pain medication prescribed to an individual with a terminal illness.
Unified PA Process – includes eligibility and coverage too

- **Unifies** the prior authorization process to include not only a determination of **medical necessity** but also a determination of whether the individual is **covered** by the health plan and eligible for the particular **benefit**.
23-99-1109
Rescission of PAs

- **Prohibits rescission** (withdraw) of authorizations *for lack of medical necessity* unless the utilization review entity notifies the provider *three business days prior* to the scheduled service that the authorization is being rescinded.
Exception:

- Individual was no longer covered on date of service – and insurer has provided means for provider to check patient’s status up to day of service.
  - “Green light” – Patient is covered.
  - “Yellow light” – Patient is in grace period.
  - “Red light” – Patient is no longer covered.
Guarantees payment of claims for services that were prior authorized unless:

- the service is never provided,
- the claim for the service is not submitted in a timely fashion,
- the patient has exhausted a benefit limitation in his or her plan, or
- the utilization review entity has evidence of misrepresentation, fraud, or abuse by the provider or subscriber.
Makes authorizations **effective for 90 days**.

Requires insurers to strive to implement by July 1, 2018, an **automated electronic process** as a voluntary alternative to providers requesting prior authorization by telephone.
• 23-99-1110 (existing law)  
Waiver of Act 815 prohibited

• 23-99-1111  
Requests for PAs – Qualified persons authorized to review and approve

- Allows non-physician staff to review and approve prior authorizations – but requires denial decisions be made by a physician with an unrestricted Arkansas medical license.
23-99-1112
Application of existing law

- Technical correction addressed earlier through definitions
Benefit inquiries authorized ("Voluntary" PA)

Mandates a procedure for benefit inquiries ("voluntary" prior authorization) whereby a provider can know whether a service will be paid for a particular patient before providing the service even if the insurer does not require prior authorization. Allows longer response time (10 business days).
Benefit inquiries (cont) -

Rule 115 of 2018:

- Minimum threshold -- Insurers are required to follow “benefit inquiry” process if the service or procedure is at least $1500 based on provider’s billed charges. (Rule 115 of 2018)

- The patient must be covered under a plan or policy in force at time of benefit inquiry.
Limitations on step therapy

- Prohibits insurers from requiring patients to switch to a different drug under a "step therapy" requirement if the patient has already gone through step therapy for that drug, even though the insurer may change its drug formulary or pharmacy benefits manager.
Notice requirements

- Mostly existing law - amends notice to add phone number for substitute reviewer if responsible physician not available.
• 23-99-1116 (existing law)  
  PA deemed approved if insurer does not comply with Act

• 23-99-1117  
  Standard form for prescription drugs

  Reverts the requirement for response time for prior authorization for all prescription drugs to 72 hours as was original intent.
Prohibits insurer audit recoupments for services approved by a compliant prior authorization except in the limited circumstances listed above.

Makes clarifying and technical corrections to the original statutory language.
RULE 114
PRIOR AUTHORIZATIONS FOR PAIN MEDICATIONS
FOR TERMINAL ILLNESSES

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SECTION 1. AUTHORITY

This Rule is issued pursuant to Ark. Code Ann. § 23-99-414 which authorizes the Arkansas Insurance Commissioner ("Commissioner") to promulgate rules necessary to carry out the "Arkansas Health Care Consumer Act" subchapter. Act 992 of 2015, "An Act to Regulate the Prior Authorization Procedure for Treatment of a Terminal Illness," adds various provisions to the prior authorization section in the “Arkansas Health Care Consumer Act” pertaining to prescription pain medication for persons with terminal illnesses. This Rule is also issued pursuant to Ark. Code Ann. § 23-61-108(a)(1) and (b)(1). The requirements in Act 992 of 2015 were not later codified in the Prior Authorization subchapter in Act 1106 of 2015, the "Prior Authorization Transparency Act." The Arkansas Insurance Department ("Department") however interprets the provisions in Act 992 of 2015 to be enforceable and valid as enacted. The Department is also promulgating the requirements in Act 992 of 2015 to clarify their application to health benefit plans as defined in this Rule, subject to requirements of this Rule.

SECTION 2. DEFINITIONS

(1) “Covered person” means a “covered person” as defined in Ark. Code Ann. § 23-99-403(3);
(2) “Health benefit plan” means a “health benefit plan” as defined in Ark. Code Ann. § 23-99-1103(7);
(3) "Healthcare insurer" means a “healthcare insurer” as defined in Ark. Code Ann. § 23-99-1103(8);
(4) "Prescription pain medication" means any medication prescribed as treatment for pain;
(6) "Terminal illness" means an illness, a progressive disease, or an advanced disease state from which: (A) there is no expectation of recovery; and (B) death as a result of the illness or disease is reasonably expected within six (6) months; and
(7) "Utilization review entity" means a "utilization review entity" as defined in Ark. Code Ann. § 23-99-1103(21);

SECTION 3. PAIN MEDICATION AUTHORIZATIONS

If a prescription pain medication requires a prior authorization by a healthcare insurer or utilization review entity, a prior authorization for prescription pain medication shall not be denied to a covered person with a terminal illness by a healthcare insurer or utilization review entity, however, coverage for individual prescriptions may be subject to quantity limits and FDA approval as provided in the health benefit plan and may be monitored by the utilization review entity or healthcare insurer to limit drug diversion and abuse.

SECTION 4. EFFECTIVE DATE

The effective date of this Rule shall be June 27, 2016.

[Signature]
ALLEN W. KERR
INSURANCE COMMISSIONER

6-21-16
DATE
RULE 115
PRIOR AUTHORIZATION TRANSPARENCY ACT

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Section 1. Authority


Section 2. Purpose

The purpose of this Rule is to implement Act 815 of 2017 of the 91st Arkansas General Assembly, "An Act To Clarify Certain Provisions Of The Prior Authorization Transparency Act" (hereafter, the "Prior Authorization Transparency Act").

Section 3. Applicability and Scope

This Rule applies to all health benefit plans as defined in Ark. Code Ann. § 23-99-1103(7).

Section 4. Definitions

Unless otherwise separately defined in this rule, the terms or phrases as used in this rule shall follow the definitions of such terms or phrases as defined in Ark. Code Ann. § 23-99-1103, or as later amended in the Prior Authorization Transparency Act subchapter.

"Benefit Inquiry" means an inquiry by an Arkansas licensed healthcare provider to a healthcare insurer utilization review entity related to medical necessity, coverage or payment for prospective
healthcare services, including prescription drugs, for an enrolled member of a healthcare plan of the applicable healthcare insurer for services or prescription drugs which are not subject to prior authorization requirements of the utilization review entity.

Section 5. Publication of Prior Authorization and Nonmedical Review Criteria & Statistics


For the statistical reporting data required under Ark. Code Ann. § 23-99-1104(d), a utilization review entity shall update the required statistics in the format and manner as required by Ark. Code Ann. § 23-99-1104(d) once each quarter of each year from the effective date of this Rule.

B. Effective Date For Reporting, Retention of Statistical Information & Application of Statistics and Clinical Criteria.

1. A utilization review entity is required to disclose the statistical information required under Ark. Code Ann. § 23-99-1104(d) for statistics from health benefit plans occurring on and after July 22, 2015.

2. A utilization review entity shall disclose and maintain the statistical information as required under Ark. Code Ann. § 23-99-1104(d) for at least a three (3) year rolling time period.

3. A utilization review entity is required to disclose statistical reporting data under Ark. Code Ann. § 23-99-1104(d) for Arkansas resident insureds in the individual market or Arkansas resident enrollees or certificate holders in health benefit plans as defined under Ark. Code Ann. § 23-99-1103(7).

4. For purposes of interpretation of Ark. Code Ann. § 23-99-1104(d)(2)(A) related to the disclosure of prior authorization data, the term, “physician specialty” refers to the medical specialty of the treating physician who has submitted the prior authorization request and not to the specialty of the medical reviewer of the utilization review entity. A utilization review entity shall disclose the physician specialty data to the extent that the utilization review entity has received physician specialty information at the time the prior authorization request is submitted.

5. For purposes of interpretation of Ark. Code Ann. § 23-99-1104(d)(2)(C), related to the disclosure of prior authorization data, the term, “indication offered,” means the medical indication, i.e., relevant diagnosis, given by the healthcare provider for the medication, test, or procedure.

Section 6. Deemer Provisions

A. Pursuant to Ark. Code Ann. § 23-99-1116(a), if a healthcare insurer or utilization review entity fails to comply with this subchapter, the requested healthcare services shall be deemed authorized or approved.
B. Pursuant to Ark. Code Ann. § 23-99-1116(b), a healthcare service that is authorized or approved under this section is not subject to audit recoupment under Ark. Code Ann. § 23-63-1801 et seq.

Section 7. Persons Conducting Reviews

A utilization review entity shall follow the requirements under Ark. Code Ann. § 23-99-1111 related to the required qualifications for persons conducting prior authorization reviews.

Section 8. Retrospective Denials on Prior Authorizations


Section 9. Accelerated Prior Authorizations

Nothing in the “Prior Authorization Transparency Act” is intended to prohibit or restrict a utilization review entity from approving a prior authorization request from a healthcare provider in a more expedited time period than the minimums set out in the provisions of the Act or this Rule.

Section 10. Benefit Inquiries Subject To Prior Authorization Requirements.

(a) Pursuant to Ark. Code Ann. § 23-99-1113(a)(2)(A), the following Benefit inquiries are subject to the requirements of Ark. Code Ann. § 23-99-1113:

Any utilization review entity responding to a benefit inquiry in which the healthcare provider’s billed charge for such services exceeds $1,500.00 shall comply with the Prior Authorization Transparency Act. No utilization review entity shall be required to provide a healthcare provider with a response under the Act if a healthcare plan or policy is not in-force at the time of such inquiry, or in the event that the member is not covered or insured under such plan at the time of such inquiry. A utilization review entity may require the healthcare provider to provide information in the inquiry describing the member or healthcare plan identification to expedite the inquiry.

Section 11. Effective Date.

The effective date of this Rule is February 19, 2018.

ALLEN W. KERR
INSURANCE COMMISSIONER