Insurance Policies – Prescription Drug Benefits

23-79-149. Prescription drug benefits.

(a) As used in this section, “insurance policy” means any individual, group, or blanket policy, contract, or evidence of coverage written, issued, amended, delivered, or renewed in this state, or which provides such insurance for residents of this state, by an insurance company, hospital medical corporation, or health maintenance organization.

(b) No insurance company, hospital medical corporation, or health maintenance organization issuing insurance policies in this state shall contract with a pharmacist, pharmacy, pharmacy distributor, or wholesale drug distributor, nonresident or otherwise, to provide benefits under such insurance policies for the shipment or delivery of a dispensed legend drug into the State of Arkansas, unless the pharmacist, pharmacy, or distributor has been granted a license or permit from the Arkansas State Board of Pharmacy to operate in the State of Arkansas.

(c)

(1) Each insurance policy shall apply the same coinsurance, co-payment, and deductible factors to covered drug prescriptions filled by a pharmacy provider who participates in the insurance policy's network if the provider meets the contract's explicit product cost determination.

(2) Nothing in this subsection shall be construed to prohibit the insurance policy from applying different coinsurance, copayment, and deductible factors between and among generic and brand name drugs.

(d) Insurance policies shall not set a limit on the quantity of drugs which an enrollee may obtain at any one (1) time with a prescription, unless the limit is applied uniformly to all pharmacy providers in the insurance policy's network.

(e)

(1) For the purpose of this subsection, “maintenance drug” means a drug prescribed by a practitioner who is licensed to prescribe drugs and used to treat a medical condition for a period greater than thirty (30) days.

(2) Insurance policies shall not insist or mandate any provider to change an enrollee's maintenance drug, unless the prescribing provider and enrollee agree to such a change.

(3) Notwithstanding other provisions of law to the contrary, insurance policies that change an enrollee's maintenance drug without the consent of the provider and enrollee shall be liable to the provider or enrollee, or both, for any damages resulting from the change.

(f) The Insurance Commissioner shall enforce the provisions of this section and shall impose and collect a penalty of one thousand dollars ($1,000) for the first violation of this section and a penalty of five thousand dollars ($5,000) for each subsequent violation of this section. In addition, the commissioner shall have all the powers to enforce this section as are granted to the commissioner elsewhere in the Arkansas Insurance Code.

(g) The commissioner shall have all the powers to enforce this section, including, but not limited to, ensuring that the different coinsurance, copayment, and deductible factors applicable between and among generic and brand name drugs are reasonable, as are granted to the commissioner elsewhere in the Arkansas Insurance Code.

Coverage for Diabetes Treatment

23-79-601. Definitions.

As used in this subchapter:

(1) "Diabetes self-management training" means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education and Support as developed by the American Diabetes Association;

(2) "Healthcare insurer" means any insurance company, fraternal benefit society, hospital and medical services corporation, or health maintenance organization issuing or delivering a health insurance policy subject to any of the following laws:

(A) The Arkansas Insurance Code;

(B) Section 23-74-101 et seq., relating to fraternal benefit societies;

(C) Section 23-75-101 et seq., pertaining to hospital medical service corporations;

(D) Section 23-76-101 et seq., pertaining to health maintenance organizations; and

(E) Any successor law of the foregoing; and

(3) "Health insurance policy" means a group insurance policy, contract, or plan or an individual policy, contract, or plan which provides medical coverage on an expense incurred, service, or prepaid risk-sharing basis. The term includes, but is not limited to, a policy, contract, or plan issued by an entity subject to any of the following laws:

(A) The Arkansas Insurance Code;

(B) Section 23-74-101 et seq., relating to fraternal benefit societies;

(C) Section 23-75-101 et seq., pertaining to hospital medical service corporations;

(D) Section 23-76-101 et seq., pertaining to health maintenance organizations; and

(E) Any successor law of the foregoing.

23-79-602. Diabetes self-management training – Licensed providers – Prescription by physician.

(a) Every health insurance policy shall include coverage for a one-per-lifetime training program per insured for diabetes self-management training when medically necessary as determined by a physician and when provided by an appropriately licensed healthcare professional upon certification by the healthcare professional providing the training that the insured patient has successfully completed the training.

(b) Every healthcare insurer shall offer, in addition to the one-lifetime-training program provided in subsection (a) of this section, additional diabetes self-management training in the event that a physician prescribes additional diabetes self-management training and it is medically necessary because of a significant change in the insured's symptoms or conditions.

(c) A licensed healthcare professional shall only provide diabetes self-management training within his or her scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his or her licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education and Support as developed by the American Diabetes Association.

(d) Diabetes self-management training shall be provided only upon prescription by a physician licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.

(e) Nothing in this subchapter shall be construed to prohibit healthcare insurers from selectively negotiating contracts with qualified providers of diabetes self-management training programs.

23-79-603. Requirements.

(a) Every health insurance policy shall include medical coverage for medically necessary equipment, supplies, and services for the treatment of Type I diabetes, Type II diabetes, and gestational diabetes, when prescribed by a physician licensed under § 17-95-201 et seq.

(b) The coverage required by this section shall be consistent with that established for other services covered by a given health insurance policy in regard to any of the following:

(1) Deductibles, coinsurance, other patient cost-sharing amounts or out-of-pocket limits; or

(2) Prior authorization or other utilization review requirements or processes.

23-79-604. Exclusions.

This subchapter shall not be construed as prohibiting a health insurance policy from excluding from coverage diabetes self-management training or equipment or supplies and related services for the treatment of Type I diabetes, Type II diabetes, or gestational diabetes when the training, equipment, supplies, and services are not medically necessary, provided that the medical necessity determination is made in accordance with generally accepted standards of the medical profession and other applicable laws and rules.

23-79-605. Rules.

The State Insurance Department shall develop and promulgate rules to implement the provisions of this subchapter.

23-79-606. Applicability – Delivery within state.

(a) This subchapter shall apply to any health insurance policy that is delivered, issued for delivery, renewed, extended, or modified in this state on or after August 1, 1997.

(b) If a health insurance policy provides coverage or benefits to an Arkansas resident, the health insurance policy shall be deemed to be delivered in this state within the meaning of this subchapter, regardless of whether the healthcare insurer or other entity that provides the coverage is located within or outside of Arkansas.

23-79-607. Applicability – Exceptions.

(a) This subchapter shall not apply to:

(1) Long-term care plans;

(2) Disability income plans;

(3) Short-term nonrenewable individual health insurance policies that expire after six (6) months;

(4) Medical payments under homeowner or automobile insurance policies; and

(5) Workers' compensation insurance.

Arkansas Coverage for Early Refills of Prescription Eye Drops Act

23-79-2201. Title.

This subchapter shall be known and may be cited as the “Arkansas Coverage for Early Refills of Prescription Eye Drops Act”.

23-79-2202. Definitions.

As used in this subchapter:

(1) “Covered person” means a person who is and continues to remain eligible for coverage under a health benefit plan and is covered under the health benefit plan;

(2)

(A) “Health benefit plan” means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by a healthcare insurer; and

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

(B) “Health benefit plan” includes:

(i) Indemnity and managed care plans; and

(ii) Nonfederal governmental plans as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2021.

(C) “Health benefit plan” does not include:

(i) A disability income plan;

(ii) A credit insurance plan;

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

(iv) A medical payment under automobile or homeowners insurance plans;

(v) 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.;

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

(vii) An accident-only plan;

(viii) A specified disease plan;

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

(x) A dental-only plan; or

(xi) A vision-only plan;

(3) “Healthcare insurer” means an entity subject to the insurance laws of this state or the jurisdiction of the Insurance Commissioner that contracts or offers to contract to provide health insurance coverage, including without limitation an insurance company, a health maintenance organization, a hospital medical service corporation, a self-insured governmental or church plan in this state, or the Arkansas Medicaid Program;

(4) “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; and

(5) “Prescription eye drops” means a prescription topical eye medication that is delivered through eye drops and is used to treat a chronic condition of the eye.

23-79-2203. Prescription eye drops – Early refills – Requirements.

A healthcare insurer that provides coverage for prescription eye drops under a health benefit plan shall provide coverage for early refills of prescription eye drops to a covered person on and after January 1, 2022, if:

(1) For a thirty-day supply:

(A) The amount of time has passed after which a covered person should have used seventy percent (70%) of the dosage of the prescription eye drops according to a healthcare professional's instructions on the prescription; or

(B) Twenty-two (22) days have passed from:

(i) The original date the prescription eye drops were distributed to a covered person; or

(ii) The date the most recent refill of the prescription eye drops was distributed to a covered person;

(2) The healthcare professional indicates on the original prescription that additional quantities of the prescription eye drops are needed;

(3) A refill request of a covered person for prescription eye drops does not exceed the number of additional quantities needed as described in subdivision (2) of this section; and

(4) The prescription eye drops prescribed by a healthcare professional are a covered benefit under the health benefit plan of the covered person.