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A Closer Look at Act 146

Prior Authorization Reform

Senate Bill 225

Senate Bill 225 amends Article XXI (Quality Health Care Accountability and Protection) of the Insurance Company Law of 1921, which regulates a wide range of issues affecting the relationship between managed care plans and their providers and enrollees, including plan responsibilities, utilization review of health care services and complaints. The current article only applies to managed care plans that are Medicaid managed care organizations (MCOs) and gatekeeper commercial insurance plans.

SB 225 amends the existing provisions in Article XXI to extend applicability to include all health care insurers and Medical Assistance (MA) and Children's Health Insurance Program (CHIP) managed care plans. The bill adds definitions and new sections to establish uniform standards for prior authorization, medication-assisted treatment and step therapy.

Significant elements include:

Section 2111. Responsibilities of Insurers and MA and CHIP Managed Care Plans

All PA regulated health care insurers and the state's Medicaid and CHIP managed care plans will now be governed under Article XXI. This section lists thirteen elements all insurers must comply with, including adopting and maintaining a definition of medical necessity used in determining authorization of health care services and required reporting to the PA Insurance Department on the number, type and disposition of all complaints, grievances and adverse benefit determinations filed with the insurer.

Section 2116. Emergency Services

Explicitly states that insurers/MA/CHIP can't require a health care provider to submit a request for prior authorization for an emergency service.

Section 2153. Provider Portal

Within 18 months of the effective date of this section (Jan. 2023) insurers/MA/CHIP are required to have established a provider portal on their publicly accessible website that includes electronic submission of prior authorization requests, access to applicable medical policies, information regarding how to request peer-to-peer review, contact information for the insurer's relevant clinical or administrative staff and instructions for submission of prior authorization requests if the portal is unavailable for any reason. Within six months following establishment of a provider portal the insurer/MA/CHIP shall make access to training available to health care providers and their staff on the use of the portal.

Section 2154. Medical Policies and Clinical Review Criteria

Insurers/MA/CHIP are required to make current medical policies available through their provider portal and publicly accessible website, review each medical policy annually and notify providers of changes at least 30 days prior to application. Each medical policy shall identify the clinical review criteria used in the policy development. The clinical review criteria adopted must be based on applicable nationally recognized medical standards, be consistent with governmental guidelines, provide for the delivery of clinically appropriate care and reflect current medical and scientific evidence regarding emerging procedures, clinical guidelines and best practices as articulated in independent peer-reviewed medical literature.

Section 2155. Prior Authorization Review

(A) An insurers/MA/CHIP is required to make a prior authorization determination based on its medical policy, administrative policy, all relevant medical information related to the covered person and any medical or

scientific evidence submitted by the requesting provider. At the time of review insurers/MA/CHIP shall verify the covered person's eligibility.

(B) Insurers/MA/CHIP shall list on their publicly accessible website the health care services which require prior authorization.

(C) Upon receipt and review of a prior authorization request insurers/MA/CHIP must notify the health care provider of any missing information necessary to make a determination and shall identify such information with sufficient specificity to allow the provider to submit what is necessary.

(D) A request for prior authorization may only be denied after review by, or in consultation with, a licensed health care provider with appropriate training, knowledge or experience in the same or similar specialty that typically manages or consults on the health care service in question.

(E) If a prior authorization request is denied the insurer/MA/CHIP must make a peer-to-peer review available. The peer reviewer shall meet the same qualifications as described in (D) and must have the authority to modify or overturn the prior authorization decision. The procedure for requesting a peer-to-peer review must be available on the insurer/MA/CHIP provider portal and publicly available website.

(F) A health care provider may designate another licensed member of the provider's clinical staff as a qualified proxy to complete the peer-to-peer review. The proxy must be qualified to perform or prescribe the requested health care service and must have knowledge of the covered person's condition and the requested procedure.

(G) Peer-to-peer review shall be available to a requesting health care provider from the time of a prior authorization denial until the internal grievance process or internal adverse benefit determination process commences.

(H) Determination on prior authorization requests submitted to **MA/CHIP** shall be communicated within 2 business days of the receipt of all supporting information reasonably necessary to complete the review.

(I) Determinations on prior authorization requests submitted to **insurers** shall be made within the following timelines:

1) Urgent health care service – as soon as possible but not more 72 hours after submission. If related to an ongoing urgent health care service and the request is made at least 24 hours prior to reduction or termination of the treatment, within 24 hours.

2) Non-urgent health care service – within 15 days of submission.

3) Prescription drug or Step Therapy- if urgent then within 24 hours; all others within 2 business days but not more than 72 hours.

(J) Insurers/MA/CHIP can't deny a claim for a closely related service for failure to get prior authorization provided the health care provider notifies the insurer no later than 3 days after completion of the service but prior to submission of the claim.

(K) Upon denial of a prior authorization request insurers/MA/CHIP are required to provide covered persons with a specific statement detailing appeal rights

Section 2156. Step Therapy Considerations

If an insurer/MA/CHIP has a medical policy that includes step therapy criteria for a prescription drug it must include as part of its prior authorization process a request for an exception to its step therapy criteria. A request for an exception shall be evaluated based on the covered person's individualized clinical condition and consider contraindications, clinical effectiveness of required prerequisite drugs, expected clinical outcomes of the requested drug and whether the required step therapy criteria has already been satisfied under a previous insurer.

Section 2157. Medication-Assisted Treatment

Insurers/MA/CHIP are required to make coverage available for at least one drug approved by the FDA for use in MAT for opioid use disorders, including at least one of each of the following without requiring prior authorization: Buprenorphine/naloxone prescription drug combination product; injectable and oral naltrexone; methadone. If such drug is covered as a pharmacy benefit, then the insurer shall cover the drug on the lowest non preventive cost tier.

Section 2164.1. External Review Applicability and Scope

Establishes the authority of the PA Insurance Department to receive and adjudicate external review of insurers adverse benefit determinations that are based on medical necessity, appropriateness of service, health care setting, level of care or effectiveness of a covered benefit.

Section 2164.2. Notice of Right to External Review

Insurers must notify covered persons of their right to request an external review at the same time the insurer sends written notice of an adverse benefit determination.

Section 2164.10. Minimum Qualifications for Independent Review Organizations.

Clinical reviewers assigned to conduct external reviews must be a physician or other appropriate health care provider who has expertise in the treatment of the covered person's condition, is knowledgeable about the recommended health care service, is board certified in the area of medicine appropriate to the subject of the review and has no history of disciplinary action.

Effective Date:

Section 2153 requiring development of provider portals goes into effect in January 2023.

Remainder of bill goes into effect January 2024.

For more information

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