



SUMMARY OF SB 225-AS AMENDED
POSITIVE CHANGES TO BENEFIT PATIENTS & PROVIDERS

OVERVIEW

SB 225, as amended in the House of Representatives, is the most comprehensive patient protection bill considered by the legislature in two decades. The bill provides standardized parameters that govern the relationships between patients, providers and insurers or managed care plans in making health care coverage decisions. It does no harm to cost containment measures such as prior authorization or step therapy, but it does ensure optimal treatment for patients. This amendment differs from the original SB 225 passed by the Senate and includes clear agreed-to language standardizing timeframes, addressing needs for Medication Assisted Treatment, sharpening transparency in medical policies, notices and data collection requirements as consumer protections. It also more appropriately combines external appeal provisions and the inclusion of Medicaid managed care plans. Plainly stated, this bill reduces paperwork and administrative time for providers, clarifies needs in submission of prior authorization requests for more than 80 percent of Pennsylvanians. It does not increase costs, nor does it expand Medicaid. Below is a specific summary of the points that will positively impact medical providers and patients with the passage of this bill.

SPECIFIC POLICY ACCOMPLISHMENTS FOR PATIENTS AND PROVIDERS

1. Expands reforms to prior authorization to now include **all** insurers plus the state's Medicaid and CHIP managed care plans.
2. Clearly defines "closely related services" which now do not require prior authorization. Closely related services include any service a "prudent health care provider reasonably expected to perform in conjunction with or in lieu of an originally authorized service in response to minor differences in patient characteristics or needs for diagnostic information not readily identifiable before performing the authorized service."
3. Expands the definition of an urgent health care service to include "treatment of an acute condition with symptoms of sufficient severity that the absence of significant medical intervention is likely to result in serious, long-term health complications or a material deterioration in the enrollee's condition and prognosis."
4. Medically Assisted Treatment: Mandates insurers make at least one FDA approved Buprenorphine/naloxone prescription drug combination product, Injectable and oral Naltrexone, and Methadone available for OUD treatment without prior authorization. The insurer may designate preferred mediations when multiple medications are available at the lowest cost tier for patients.
5. Time Frames for decisions – from time of *submitting* a request (current law is from time of a "complete request"):
 - a. Urgent health care services: as soon as possible, but no more than 72 hours. If request is made 24 hours prior to reduction or termination of existing treatment, within 24 hours.
 - b. Non-urgent medical services: not more than 15 days from submission.
 - c. Prescription drugs –
 - i. Urgent requests not more than 24 hours.
 - ii. Standard requests, two business days not to exceed 72 hours in total.
6. Requires prior authorization may only be denied *after* review by or consultation with a licensed medical professional in the same or similar specialty.
7. Established a system where a peer-to-peer review must be offered by an insurer using a reviewing physician employed in same or similar specialty as the physician submitting the

prior authorization request. Physicians submitting the prior authorization request can delegate a proxy who is a licensed professional, such as another physician, resident, physician's assistant, or nurse practitioner, to complete the peer-to-peer review. This restores the ability of submitting physicians maximize patient treatment time.

8. If at any time after requesting prior authorization, the health care provider determines the enrollee's medical condition requires emergency services, then the emergency services may be provided without prior authorization.
9. Upon submission and review by an insurer, if a request prior authorization is missing clinical information necessary to complete a review, the insurer **must notify the provider that information is missing as soon as reviewed**, and the insurer must provide enough specificity to the submitting provider to enable identification of the necessary information required to complete review. The insurer may extend the provider up to 45 additional days beyond the time limits if necessary to obtain the missing information.
10. Significantly expands the definition of what constitutes “medical or scientific evidence” and clinical standards to support approvals.
11. Establishes clear transparency requirements including:
 - a. A requirement that insurers adopt, maintain, supply on request a published definition of medical necessity easily understandable by the layperson.
 - b. A requirement that a list of all services and drugs requiring prior authorization be provided and available online.
 - c. A requirement that insurers report number, type and disposition of all complaints and grievances and adverse benefit determinations, filed to the Insurance Department for enforcement and compliance.
 - d. A requirement that insurers post their medical policies on their websites and on patient portals.
 - e. A requirement that insurers review each adopted medical policy on an annual basis and notify providers of changes at least 30 days prior to application.
12. Requires insurers to adopt and maintain a process for a patient or a provider to request that step therapy not be applied to a request for prior authorization of a prescription drug. This

section also outlines clear time frames for a determination of such a request as outlined above.

13. Clarifies continuity of care provisions apply for 60 days for patients after being notified that their physician's contract is being terminated, and through postpartum care related to delivery if patient is in second or third trimester of pregnancy.
14. Continuity of care provisions also clarify that a patient with a new health plan may continue ongoing course of treatment with a nonparticipating provider for up to 60 days from enrollment – which may be extended if clinically appropriate. Same applies to patients in second or third trimester of pregnancy.
15. Creates a requirement that insurers adopt procedures for an enrollee with a life-threatening, degenerative, or disabling disease or condition can receive a standing referral to a specialist.
16. Expands definition of emergency services and clarification that no prior auth is required, with inclusion of testing and other diagnostic services medically necessary to diagnose, evaluate or treat an emergency medical condition. Includes emergency medical service providers as emergency service providers.
17. Assures treating health care network sufficiency through the requirement that insurers, MCOs and contractors assure availability and accessibility of adequate health care providers in a timely manner.
18. Requires that all insurers and MA/CHIP managed care plans pay all clean claims within 45 days of receipt of the claim.
19. Creates a prohibition against gag clauses regarding processes and denials between patients and providers so that a whistleblower could come forward.
20. Within 18 months of passage, requires insurers to establish a provider portal that includes electronic submission of PA requests; access to applicable medical policies; information to request peer-to-peer review; contact information for insurer's relevant clinical/administrative staff; instructions for submissions.
21. Within six months of passage, requires insurers to make access to training available on the use of the portal to providers and affiliated/employed staff.

22. Dictates the processes that insurers and MA or CHIP managed care plans follow to properly establish internal appeal process, including an expedited appeal process, which gives the patient or provider the right to have the denial of prior authorization reviewed and reversed if appropriate. This process includes a review by a physician in the same or similar specialty.
23. Restores the ability of the Pennsylvania Insurance Department to receive and adjudicate external appeals brought before it on coverage, medical necessity, appropriateness of new or investigational treatment by a patient or provider and mandates that such review involve a physician in the same or similar specialty, with written decisions being rendered within 60 days. An important provision which now enables legislative oversight and potential legislative referral of aggrieved constituents seeking a determination.

CONCLUSION

This amendment is the product of four months of intensive negotiation with all stakeholders – providers, patient advocates, insurers, hospitals and state regulatory agencies - who made their opinions known and voices heard. Not one stakeholder was turned away or unheard. The language is largely agreed upon by the relevant stakeholders and while no one stakeholder received complete satisfaction through getting all of its “asks,” each stakeholder can agree this is a workable bill that is a substantial improvement to health care in the Commonwealth of Pennsylvania. We ask for you to support the Amendment and ultimately SB 225 on final passage.