Pennsylvania

Pennsylvania - HB 225

Sponsor: Representative Steven Mentzer (R)

Actions: 04/01/2021 Introduced; Referred to Insurance Committee

Summary: Summary for 4/1/2021 Version

This bill amends the insurance law to change definitions and requirements relating to preauthorization, in particular mandating certain new responsibilities, simplifications, and standards.

This bill makes a series of changes to the definitions and obligations relating to utilization reviews and pre-authorization in Pennsylvania. Definitions, and when applicable associated responsibilities are listed below.

Definitions:

Administrative defect: an error or omission other than information medically necessary which is used to deny a utilization review. 30 days shall be allowed to correct such defects.

Adverse determination: a decision in response to a preauthorization request that denies a service as unnecessary. This shall be provided to the insured and their provider along with instructions for appeal.

Appeal: a formal request to reconsider the above

Appeal procedure: The process by which the insured, or their physician/facility, appeal a decision. Must be conducted by a physician not involved in the initial adverse determination.

Authorization: Approval and commitment to payment for a procedure.

Clinical criteria: Evidence based professional standards used for determining eligibility for approval under utilization review. Subject to annual update, community standards of care, etc.

Emergency service: Updated to include pre-hospital transport.

Enrollee: Definition removed. Later references to enrollee are replaced with "insured."

Expedited appeal: A formal request to reconsider denial for urgent or emergency services.

Final adverse determination: An adverse determination upheld by an internal review process.

Grievance: Definition amended to note that it is after the service has been performed.

Health care service: Removes definition that "service" must be covered to be a service. Now includes diagnostic tests.

Medically necessary healthcare services: Those which prevent diagnose or treat an injury or illness, and are in accordance with generally accepted standards of care.

Medication assisted treatment: Treatments using FDA approved drugs, including those for substance use disorder.

NCPDP SCRIPT Standard: The National Council for Prescription Drug Programs SCRIPT Standard Version 201310, or its most recent compatible version.

Nonurgent health care service: A health care service that is not urgent or emergency.

Preauthorization: Replaces prospective utilization review.

Retrospective review: Amended to note it may not be used to change the results of a service approved under preauthorization.

Step therapy protocol/exception: Establishes a specific program sequence for medicinally appropriate drugs, and exceptions thereof to go immediately to certain care. The bill also outlines in another section the process through which step therapies shall be established and updated, including peer-review, public notice and comment. Additionally step therapy exception applications shall be made readily and clearly available to the insured and physicians. Insurers are also required to publish yearly statistics on these exceptions, their requests and accessions.

Urgent healthcare service: One which, if delayed, could result in severe suffering or detriment to health.

Utilization review entity: Specifies that the term includes employers, insurers, pharmacy benefits managers, and any other individuals who manage said benefits.

Responsibilities of Managed Care Plans

Managed care plans must publish changes to enrollment requirements within 30 days. Failing to do so bars plans from denying coverage under such eligibility requirements. Additionally, timely filing rules must commence upon either patient discharge or preauthorization approval.

Preauthorization Standards:

The Insurance department shall develop a universal preauthorization form to be accepted as sufficient by insurers, drawn up by a panel of at least 10 people representing various segments of the health care industry, within one year of enactment.

The department shall also yearly publish a report detailing claims against utilization review entities and their ultimate determination, with related statistics.

Preauthorization requests shall be accessible to relevant parties and filed through electronic means within 180 days of the effective date, unless the provider does not have internet access/an electronic health record system, or is experiencing a temporary outage.

NCPDP SCRIPT Standard shall be acceptable for pharmaceutical care.

Any restriction placed on preauthorization shall be based on medical necessity and applied consistently.

Preauthorization is not required for treatments which are customary for a certain conditions, or for treatments for opioid use disorders. Preauthorization may not be denied for continuity of care.

Where one is insured by more than one plan: Preauthorization by the primary insurer disallows the secondary insurer from denying based on their preauthorization process not being followed. Denial by the primary insurer does not preclude approval by the secondary. Appeals and external reviews shall be provided without cost to the insured/medical provider.

Changes to preauthorization requirements shall be published and communicated to affected parties at least 60 days in advanced. Utilization review entities shall also maintain a publicly available list of procedures requiring preauthorization and the requirements thereof.

Utilization review entities shall allow the insured at least one business day for notification of admission to an emergency facility.

Preauthorization approvals are effective for 180 days or the length of the treatment.

Only strictly relevant medical records may be requested for preauthorization review.

Failure to comply with these requirements and deadlines shall result in the service being deemed preapproved, and the managed care organization responsible for paying.

Preauthorization and payment shall not apply if the insured was not eligible for benefits at the time the health care service was performed, or if material information was not submitted that would have resulted in denial, or if the insured otherwise participated in fraud.

Utilization review entities shall ensure that final preauthorization reviews or denials are issued by currently licensed physicians. The insured and their provider shall have the right to discuss a denial based on medical reasoning with this reviewing physician.

Preauthorization may not be required for emergency services.

This bill is effective 60 days after enactment.

Bill Links 4/1/21 Version

Pennsylvania - HB 762

Sponsor: Representative Anthony DeLuca (D)

Actions: 03/03/2021 Introduced; Referred to House Health Committee
12/16/2020 Co-Sponsor Memo Published

Summary: Summary of 3/3/2021 Version

Creates a certificate of need review board to which any expansion of or establishment of a health care facility must submit their request for construction, establishment or expansion. This board will terminate in four years and the legislature will review its effect on healthcare quality.

This bill is applicable to the Health Policy Board, the Department of Health, and health facilities regulated under the Health Facilities Act.

This bill reenacts the Health Care Facilities Act and amends it to create a Certification of Need board that is appointed by the Secretary of Health and consists of experts in relevant fields, to develop qualitative and quantitative standards for approval of certificates of need and to prepare and publish a state health services plan within 18 months of the effective date of this bill. it also modifies fees and damages.

Any person or health care facility or organization or provider must receive, alongside previous requirements, a certificate of need for an expansion, construction, renovation or other undertaking over 2 million dollars for any hospital improvement, for any high-cost technology or replacement technology, or for equipment in an ambulatory surgical facility or office where reviewable clinically related health care services are offered. New facilities or services must also seek a certificate of need.

The bill provides for the procedures for considering these proposals and how the review board will interact with other community authorities before authorizing these projects, while considering their impact on healthcare costs and whether there is another, more appropriate measure as far as costs or impact on healthcare quality in the region. After four years, this board will expire and the Legislative Budget and Finance Committee will review its impact on healthcare quality.

This bill is effective 90 days after passage.

Bill Links 3/3/2021 Version
12/16/2020 Version

Pennsylvania - HM 34236

Sponsor: Representative Steven Mentzer (R)

Actions: 01/19/2021 Co-Sponsorship Memo

Summary: Summary for 1/19/2021 Version

This measure will establish a basic framework for when it is medically appropriate to exempt a patient from step therapy.

In his memo, Rep. Mentzer (R) writes: "We all know that administrative waste in the healthcare delivery system is significant. We have all, at one time or another, experienced our healthcare provider recommending a course of treatment or medication “pending the approval of your health insurance company.” This approval process is commonly referred to as prior authorization, or PA.

As you might expect, PA is one example of an inefficient process that increases costs across the healthcare system--for both providers and patients--and one which routinely jeopardizes patient care by often delaying or denying treatment.

PA was initially used by health insurers to minimize the overuse of expensive healthcare services such as MRIs, CAT Scans, and other cutting-edge diagnostics and medications. However, health insurers are now requiring physicians and other healthcare providers to secure prior authorization for routine tests, medications, and procedures that fall well within accepted standards of care. In fact, many health insurers are now requiring PAs for generic medications.

In addition to PA, my proposal addresses the issue of step therapy. Step therapy is routinely used by health insurers to limit how much is spent covering patients’ medications. Under a step therapy protocol, a patient must try one or more drugs chosen by their insurer—usually based on cost, not medical, considerations—before coverage is granted for the drug prescribed by the patient’s healthcare provider. Patients may be required to try one or more alternative prescription drugs that are of lower cost to the insurer, but which may not be the best therapy for them. While this process may seem benign, patient health often declines as they “try and fail” on alternative medications. I believe there needs to be a balance between cost control and patient need. This proposal would establish a basic framework for when it is medically appropriate to exempt a patient from step therapy.
The criteria for whether to approve a prior authorization request or to require step therapy varies widely from one health insurer to another, frustrating providers who want to treat their patients according to accepted clinical protocols and guidelines. In other words, they want to do what is in the best interest of their patients. While my proposal does not prohibit the use of PA or step therapy by health insurers, it does promote transparency and it establishes important safeguards to ensure that patients get the care they need."

This memo does not specify an effective date.

Bill Links 1/19/2021 Version

Pennsylvania - HM 36009

Sponsor: Representative Dawn Keefer (R)

Actions: 07/22/2021 Filed

Summary: Summary for 07/22/2021 Version

This memo states the intent of the Representative to introduce legislation allowing for the prescribing and dispensing of off-label drugs approved by the United States Food and Drug Administration to treat Coronavirus infections causing respiratory-syndrome-related illnesses.

According to the sponsor: "My legislation would allow prescribers to prescribe and require a pharmacist to dispense a therapeutic drug approved by the United States FDA so long as it is in accordance with a prescription drug order and with the patient's consent. In addition, my legislation will allow for drugs such as hydroxychloroquine sulfate and ivermectin to be used at home or early-stage outpatient or hospital inpatient for individuals who wish to treat coronavirus infections causing respiratory-syndrome-related illnesses."

Bill Links 7/22/2021 Version

Pennsylvania - SB 317

Sponsor: Senator Patrick Browne (R)

Actions:

04/21/2021	Referred to House Health Committee
04/20/2021	Passed Senate; Introduced in House
04/19/2021	Hearing Held; Passed Committee
03/24/2021	Referred to Senate Appropriations Committee
03/23/2021	Hearing held; Passed Senate Health and Human Services Committee
03/10/2021	Introduced; Referred to Senate Health and Human Services Committee

Summary: Summary for 3/10/2021 Version

This measure amends Pennsylvania code to provide dispensing requirements for certain drugs.

This measure provides that a health care practitioner may issue a prescription for or personally furnish antibiotics to treat sexually transmitted infections, without having examined the individual for whom the drug is intended, in accordance with the Expedited Partner Therapy in the Management of Sexually Transmitted Diseases guidance document issued by the United States Centers for Disease Control and Prevention under certain circumstances. These circumstances include:

(1) The individual is a sexual partner of the health care practitioner's patient;

(2) The patient has been diagnosed with a sexually transmitted infection;

(3) The patient reports to the health care practitioner that the individual is unable or unlikely to be evaluated or treated by a health professional.

This measure provides that if the health care practitioner is unable to obtain the individual's name, the prescription will include the words "expedited partner therapy" or the letters "EPT."

This measure will take effect in 90 days.

Bill Links 3/10/2021 Version

Pennsylvania - SM 33624

Sponsor: Senator Michele Brooks (R)

Actions: 12/18/2020 Co-Sponsor Memo Published

Summary: Summary for 12/18/2020 Version

This measure will extend the Statute of Limitations for Drug Delivery Resulting in Death.

This measure is applicable to the statute of limitations for drug delivery resulting in death.

In her memo, Sen. Michele Brooks (R) states: "I plan to introduce legislation that will extend the statute of limitations for prosecuting crimes involving a drug delivery that resulted in death.

Under current law, Drug Delivery Resulting in Death (18 Pa.C.S. Section 2506) is a Felony 1, subject to a two-year statute of limitations under 42 Pa.C.S. Section 5552 (a). This time frame is far shorter than many other crimes resulting in death, such as voluntary manslaughter, murder in any degree, and accidents involving death or personal injury.

According to the Mercer County District Attorney and the Pennsylvania District Attorneys Association, this two-year time limit has interfered with the prosecution of an egregious case in northwestern Pennsylvania and is undoubtedly affecting prosecutions throughout the Commonwealth. By extending the statute of limitations from two years to five, this legislative oversight will be addressed, and we will be better able to bring parties who are responsible for a fatal overdose to justice.

Given the serious nature of such an offense, it is important that we are able to prosecute those charged with this crime, without the limitation of a tight two-year time frame."

This memo does not provide an effective date.

Bill Links 12/18/2020 Version
