PCMA Concerns with HB 711 & SB 177 (Prior Authorization)

Section 10: Applicability and Scope

- Pg. 2, Line 8: The bill excludes state employee health plans from the proposed limitations on prior authorization. We believe that there should be parity between state-funded health coverage and private plans.

Section 20: Disclosure and Review of Prior Authorization Requirements

- Pg. 5, Line 17: Making all prior authorization requirements, including clinical review criteria, available to the general public is not necessary. We support transparency of information to providers, members, and prospective members, but the bill would require a level of granularity that we do not support. Our preference is the provider has access to the specific clinical review criteria applicable to the member they are seeing; these clinical guidelines may also be based on proprietary external sources.

- Pg. 7, Line 13-16 and lines 23-26: A prior authorization could not be denied for off label use.

- Pg. 8, Line 14: We fully believe that members and their providers should be made aware of new prior authorization requirements or changes to existing requirements. However, per market research, our member companies believe that patients and providers respond better to notices within 30 days rather than 60 days.

- Pg. 8, line 25 through Pg. 10, line 5: The posting of these extensive statistics should be removed. It is unnecessary and could cause confusion to patients and providers.

Section 30: Utilization Review Program's Obligations with Respect to Prior Authorizations Concerning Urgent Health Care Services

- Pg. 11, Line 6: For the purposes of facilitating urgent care prior authorization requests, the bill would require health plans/PBMs to establish a 24/7 hotline staffed by licensed clinical personnel with access to physicians for consultations. Health plans/PBMs in many states have strict prior authorization deadlines with which they must comply for emergency and non-emergency prior authorization requests. To meet those deadlines, they must ensure that they have the systems in place to respond to prior authorization requests within the specified time periods. However, the proposed hotline is not currently done by many companies. The increases in staffing needed to comply with this bill will result in significant increases in costs.

Section 40: Personnel Qualified to Make Adverse Determinations

- Pg. 12, Line 13: The bill specifies what types of physicians are qualified to make adverse determinations for a utilization review program must ensure that all adverse determinations are made by a physician. We think the requirements are too restrictive. Health plans/PBMs may call upon licensed physicians but who may not actively practice within the jurisdiction or

necessarily within the same specialty but who understand the medical science and can speak to the therapies.

- Pg. 12, Line 14: See above. Would require such physicians to be licensed in the state of Illinois. For the reasons stated above, we think this is too restrictive.

Section 50: Requirements Applicable to the Physician Who Can Review Consultations and Appeals

- Line 18: With regard to consultations, as in section 40, we don't think the proposed requirements for physicians are necessary.

Section 55: Limitation on Prior Authorization

- Pg. 14, Line 19: A medication may be "customary and properly indicated" for the treatment of a condition, but are still dangerous, or are classified under the FDA's Risk Evaluation and Mitigation Strategy (REMS) and should require prior authorization.

- Pg. 14, Line 23: Even for patients "currently managed with an established treatment regimen," it is important to have periodic review and to require prior authorization. An open-ended PA does not take into account new treatments that may become available, more cost effective solutions and is not good medical treatment.

- Pg. 14, Line 25: Current Illinois law (P.A. 100-1024 (Sec 30)) already removes prior authorization and step therapy requirements on medications for substance use disorders other than those required per ASAM criteria. (215 ILCS 5/370c)

Section 60: Denial

- Pg. 15, line 4: Appears to create an open-ended PA.

Section 65: Length of Prior Authorization

- Pg. 16, Line 9: We think this section needs to be tightened for two reasons: 1) there's an exception for controlled substances in the existing code, so we added that language; and 2) the typical length of an insurance contract is 12 months, so that should correlate with the length of a prior authorization.

- Pg. 16, Line 13: The bill proposes that a prior authorization would remain in place for 12 months regardless of any changes, including in dosage. We believe that this should be removed from the bill because significant changes in dosage could change whether the members continued to meet clinical guidelines.

Section 70: Length of Prior Authorization for Treatment for Chronic or Long-term Care Conditions

- Pg. 16, Line 23: The bill refers to “long-term care” conditions. We have heard that PBMs have areas on their prior authorization forms for “chronic conditions” but not “long-term care conditions.”

- Pg. 17, Line 1: The bill attempts to create a valid prior authorization for the life of a chronic or long-term care condition, but those prior authorizations should not be extended indefinitely, as the course of someone’s condition may change, necessitating new or adjusted treatments. We believe a better approach for chronic conditions is that a prior authorization should remain valid for the lesser of 12 months or the standard course of treatment for that chronic condition.

Section 75: Continuity of Care for Enrollees

- Pg. 17, Line 12: When transitioning health plans, we believe that there should be ease for the member integrating into a new plan, but that should not create new benefits. We believe the prior authorization for a prescription drug from a member’s previous plan should be valid for no longer than 30 days after a member transitions to her new plan—and only for drugs that are covered by her new plan. This would be in line with the step therapy exceptions process in current law at 215 ILCS 134/45.1.