

**SUBSTITUTE FOR
SENATE BILL NO. 612**

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
by amending section 2212c (MCL 500.2212c), as added by 2013 PA 30,
and by adding section 2212e.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 2212c. (1) ~~On or before~~ **By** January 1, 2015, the workgroup
2 shall develop a standard prior authorization methodology for use by
3 prescribers to request and receive prior authorization from an
4 insurer ~~when a policy, certificate, or contract~~ **if a health benefit**
5 **plan** requires prior authorization for prescription drug benefits.
6 The workgroup shall include in the standard prior authorization
7 methodology the ability for the prescriber to designate the prior
8 authorization request for expedited review. In order to designate a



1 prior authorization request for expedited review, the prescriber
 2 shall certify that applying the ~~15-day standard~~ **5 business day**
 3 review period may seriously jeopardize the life or health of the
 4 patient or the patient's ability to regain maximum function.

5 (2) A prescription drug prior authorization workgroup is
 6 created. ~~Within 30 days after the effective date of this section,~~
 7 ~~the~~ **The** department of ~~community health~~ **and human services** and the
 8 department ~~of insurance and financial services~~ shall work together
 9 and appoint members to the workgroup. The workgroup must consist of
 10 a member who represents the department of ~~community health~~ **and**
 11 **human services**, a member who represents the department, ~~of~~
 12 ~~insurance and financial services~~, and members who represent
 13 insurers, prescribers, pharmacists, hospitals, and other
 14 stakeholders as determined necessary by the department of ~~community~~
 15 ~~health~~ **and human services** and the department. ~~of insurance and~~
 16 ~~financial services~~. The workgroup shall appoint a chairperson from
 17 among its members. The chairperson of the workgroup shall schedule
 18 workgroup meetings. The department of ~~community health~~ **and human**
 19 **services** and the department ~~of insurance and financial services~~
 20 shall organize the initial meeting of the workgroup and shall
 21 provide administrative support for the workgroup.

22 (3) In developing the standard prior authorization methodology
 23 under subsection (1), the workgroup shall consider all of the
 24 following:

25 (a) Existing and potential technologies that could be used to
 26 transmit a standard prior authorization request.

27 (b) The national standards pertaining to electronic prior
 28 authorization developed by the ~~national council for prescription~~
 29 ~~drug programs~~. **National Council for Prescription Drug Programs.**



1 (c) Any prior authorization forms and methodologies used in
2 pilot programs in this state.

3 (d) Any prior authorization forms and methodologies developed
4 by the federal ~~centers for medicare and medicaid services.~~**Centers**
5 **for Medicare and Medicaid Services.**

6 (4) Beginning ~~on the effective date of this section,~~**March 14,**
7 **2014,** an insurer may specify in writing the materials and
8 information necessary to constitute a properly completed standard
9 prior authorization request ~~when a policy, certificate, or contract~~
10 **if a health benefit plan** requires prior authorization for
11 prescription drug benefits.

12 (5) If the workgroup develops a paper form as the standard
13 prior authorization methodology under subsection (1), the paper
14 form ~~shall~~**must** meet all of the following requirements:

15 (a) Consist of not more than 2 pages. However, an insurer may
16 request and require additional information beyond the 2-page
17 limitation of this subdivision, if that information is specified in
18 writing by the insurer under subsection (4). As used in this
19 subdivision, "additional information" includes, but is not limited
20 to, any of the following:

21 (i) Patient clinical information including, but not limited to,
22 diagnosis, chart notes, lab information, and genetic tests.

23 (ii) Information necessary for approval of the prior
24 authorization request under plan criteria.

25 (iii) Drug specific information including, but not limited to,
26 medication history, duration of therapy, and treatment use.

27 (b) Be electronically available.

28 (c) Be electronically transmissible, including, but not
29 limited to, transmission by facsimile or similar device.



1 (6) Beginning July 1, 2016, if an insurer uses a prior
2 authorization methodology that utilizes an internet webpage,
3 internet webpage portal, or similar electronic, internet, and web-
4 based system, the prior authorization methodology described in
5 subsection (5) does not apply. ~~Subsections~~ **Subsection** (4) ~~, (8),~~
6 ~~and (9) apply~~ **and section 2212e apply** to a prior authorization
7 methodology that utilizes an internet webpage, internet webpage
8 portal, or similar electronic, internet, and web-based system.

9 (7) Beginning July 1, 2016, except as otherwise provided in
10 subsection (6), an insurer shall use the standard prior
11 authorization methodology developed under subsection (1) ~~when a~~
12 ~~policy, certificate, or contract~~ **if a health benefit plan** requires
13 prior authorization for prescription drug benefits.

14 ~~(8) Beginning January 1, 2016, a prior authorization request~~
15 ~~that has not been certified for expedited review by the prescriber~~
16 ~~is considered to have been granted by the insurer if the insurer~~
17 ~~fails to grant the request, deny the request, or require additional~~
18 ~~information of the prescriber within 15 days after the date and~~
19 ~~time of submission of a standard prior authorization request under~~
20 ~~this section. If additional information is requested by an insurer,~~
21 ~~a prior authorization request under this subsection is not~~
22 ~~considered granted if the prescriber fails to submit the additional~~
23 ~~information within 15 days after the date and time of the original~~
24 ~~submission of a properly completed standard prior authorization~~
25 ~~request under this section. If additional information is requested~~
26 ~~by an insurer, a prior authorization request is considered to have~~
27 ~~been granted by the insurer if the insurer fails to grant the~~
28 ~~request, deny the request, or otherwise respond to the request of~~
29 ~~the prescriber within 15 days after the date and time of submission~~



1 ~~of the additional information. If additional information is~~
 2 ~~requested by an insurer, a prior authorization request under this~~
 3 ~~subsection is considered void if the prescriber fails to submit the~~
 4 ~~additional information within 21 days after the date and time of~~
 5 ~~the original submission of a properly completed standard prior~~
 6 ~~authorization request under this section.~~

7 ~~(9) Beginning January 1, 2016, a prior authorization request~~
 8 ~~that has been certified for expedited review by the prescriber is~~
 9 ~~considered to have been granted by the insurer if the insurer fails~~
 10 ~~to grant the request, deny the request, or require additional~~
 11 ~~information of the prescriber within 72 hours after the date and~~
 12 ~~time of submission of a standard prior authorization request under~~
 13 ~~this section. If additional information is requested by an insurer,~~
 14 ~~a prior authorization request under this subsection is not~~
 15 ~~considered granted if the prescriber fails to submit the additional~~
 16 ~~information within 72 hours after the date and time of the original~~
 17 ~~submission of a properly completed standard prior authorization~~
 18 ~~request under this section. If additional information is requested~~
 19 ~~by an insurer, a prior authorization request is considered to have~~
 20 ~~been granted by the insurer if the insurer fails to grant the~~
 21 ~~request, deny the request, or otherwise respond to the request of~~
 22 ~~the prescriber within 72 hours after the date and time of~~
 23 ~~submission of the additional information. If additional information~~
 24 ~~is requested by an insurer, a prior authorization request under~~
 25 ~~this subsection is considered void if the prescriber fails to~~
 26 ~~submit the additional information within 5 days after the date and~~
 27 ~~time of the original submission of a properly completed standard~~
 28 ~~prior authorization request under this section.~~

29 ~~(8) (10) As used in this section:~~



1 (a) "Health benefit plan" means that term as defined in
2 section 2212e.

3 (b) ~~(a)~~"Insurer" means any of the following:

4 (i) An insurer issuing ~~an expense-incurred hospital, medical,~~
5 ~~or surgical policy or certificate.~~**or administering a health benefit**
6 **plan.**

7 (ii) A health maintenance organization.

8 (iii) A health care corporation operating pursuant to the
9 nonprofit health care corporation reform act, 1980 PA 350, MCL
10 550.1101 to 550.1704.

11 (iv) A third party administrator of prescription drug benefits.

12 (c) ~~(b)~~"Prescriber" means that term as defined in section
13 17708 of the public health code, 1978 PA 368, MCL 333.17708.

14 (d) ~~(e)~~"Prescription drug" means that term as defined in
15 section 17708 of the public health code, 1978 PA 368, MCL
16 333.17708.

17 (e) ~~(d)~~"Prescription drug benefit" means the right to have a
18 payment made ~~by an insurer pursuant to prescription drug~~**for a**
19 **prescription listed on the applicable formulary in accordance with**
20 coverage contained within a ~~policy, certificate, or contract~~**health**
21 **benefit plan** delivered, issued for delivery, or renewed in this
22 state.

23 (f) ~~(e)~~"Workgroup" means the prescription drug prior
24 authorization workgroup created under subsection (2).

25 **Sec. 2212e. (1) For an insurer that delivers, issues for**
26 **delivery, renews, or administers a health benefit plan in this**
27 **state, if the health benefit plan requires a prior authorization**
28 **with respect to any benefit, the insurer or its designee**
29 **utilization review organization shall, by January 1, 2022, make**



1 available a standardized electronic prior authorization request
2 transaction process utilizing an internet webpage, internet webpage
3 portal, or similar electronic, internet, and web-based system.
4 Beginning January 1, 2022, an insurer described in this subsection
5 or its designee utilization review organization and the health
6 professional shall perform a prior authorization utilizing only a
7 standard electronic prior authorization transaction process, which
8 includes the transmission of clinical information, unless the
9 health professional is not able to use the standard electronic
10 prior authorization transaction process because of a temporary
11 technological or electrical failure. The current prior
12 authorization requirements must be described in detail and written
13 in easily understandable language. The prior authorization
14 requirements must be based on peer-reviewed clinical review
15 criteria. All of the following apply to clinical review criteria
16 under this subsection:

17 (a) Unless the criteria are developed as described in
18 subdivision (h), the clinical review criteria must be criteria
19 developed by either of the following:

20 (i) An entity to which both of the following apply:

21 (A) The entity works directly with clinicians, either within
22 the organization or outside the organization, to develop the
23 clinical review criteria.

24 (B) The entity does not receive direct payments based on the
25 outcome of the clinical care decision.

26 (ii) A professional medical specialty society.

27 (b) The clinical review criteria must take into account the
28 needs of atypical patient populations and diagnoses.

29 (c) The clinical review criteria must ensure quality of care



1 and access to needed health care services.

2 (d) The clinical review criteria must be evidence-based
3 criteria.

4 (e) The clinical review criteria must be publicly available
5 free of charge.

6 (f) The clinical review criteria must be sufficiently flexible
7 to allow deviations from norms when justified on a case-by-case
8 basis.

9 (g) The clinical review criteria must be evaluated and
10 updated, if necessary, at least annually.

11 (h) For coverage other than prescription drug benefit
12 coverage, before establishing, or substantially or materially
13 altering, its own written clinical review criteria, an insurer or
14 its designee utilization review organization must obtain input from
15 actively practicing licensed physicians representing major areas of
16 the specialty. For coverage of a prescription drug benefit, before
17 establishing, or substantially or materially altering, its own
18 clinical review criteria, an insurer or its designee review
19 organization must obtain input from actively practicing licensed
20 pharmacists. If criteria are developed for a health care service
21 provided by a health professional not licensed to engage in the
22 practice of medicine under part 170 of the public health code, 1978
23 PA 368, MCL 333.17001 to 333.17097, or osteopathic medicine and
24 surgery under part 175 of the public health code, 1978 PA 368, MCL
25 333.17501 to 333.17556, an insurer or designee utilization review
26 organization must also seek input from a health professional in the
27 same profession as the health professional providing the health
28 care service.

29 (2) An insurer described in subsection (1) shall make



1 available on the insurer's public website in a readily accessible
2 format a list of all benefits that are subject to a prior
3 authorization under the health benefit plan.

4 (3) Except as otherwise provided in subsection (4), an insurer
5 described in subsection (1) or its designee utilization review
6 organization shall ensure that an adverse determination, other than
7 an adverse determination of prescription drug coverage, is made by
8 a licensed physician. For an adverse determination of a health care
9 service provided by a health professional that is not a licensed
10 physician, the licensed physician may consider input from a health
11 professional who is in the same profession as the health
12 professional providing the health care service. The licensed
13 physician shall make the adverse determination under the clinical
14 direction of 1 of the insurer's medical directors who is
15 responsible for the provision of health care items and services
16 provided to insureds or enrollees. Medical directors under this
17 subsection must be licensed to engage in the practice of medicine
18 under part 170 of the public health code, 1978 PA 368, MCL
19 333.17001 to 333.17097, or the practice of osteopathic medicine and
20 surgery under part 175 of the public health code, 1978 PA 368, MCL
21 333.17501 to 333.17556.

22 (4) An insurer described in subsection (1) or its designee
23 utilization review organization shall ensure that an adverse
24 determination of a prescription drug benefit is made by a licensed
25 pharmacist under the clinical direction of 1 of the insurer's
26 medical directors who is responsible for the provision of health
27 care items and services provided to insureds or enrollees. Medical
28 directors under this subsection must be licensed to engage in the
29 practice of medicine under part 170 of the public health code, 1978



1 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic
2 medicine and surgery under part 175 of the public health code, 1978
3 PA 368, MCL 333.17501 to 333.17556.

4 (5) If an insurer described in subsection (1) implements a new
5 prior authorization requirement or restriction, or amends an
6 existing requirement or restriction, the insurer shall ensure that
7 the new or amended requirement or restriction is posted on the
8 insurer's public website before its implementation. For a medical
9 benefit that is not a prescription drug benefit, an insurer shall
10 notify contracted health care providers via the insurer's provider
11 portal of the new or amended requirement or restriction not less
12 than 60 days before the requirement or restriction is implemented.
13 For a prescription drug benefit, an insurer shall notify contracted
14 health care providers via the insurer's provider portal of the new
15 or amended requirement or restriction not less than 30 days before
16 the requirement or restriction is implemented.

17 (6) If an insurer described in subsection (1) denies a prior
18 authorization, the insurer or its designee utilization review
19 organization shall, on issuing a medical benefit denial, notify the
20 health professional and insured or enrollee of the reasons for the
21 denial and related evidence-based criteria. Subject to subsection
22 (7), an appeal of the denial under this subsection must be reviewed
23 by a licensed health professional to which all of the following
24 apply:

25 (a) The licensed health professional is knowledgeable of, and
26 has the same or similar experience providing, the health care
27 services under appeal.

28 (b) The licensed health professional does not have a direct
29 financial stake in the outcome of the appeal.



1 (c) The licensed health professional has not been involved in
2 making the adverse determination.

3 (d) The licensed health professional considers all known
4 clinical aspects of the health care services under review,
5 including, but not limited to, a review of all pertinent medical
6 records provided to the insurer or designee utilization review
7 organization by the insured or enrollee's health care provider and
8 any relevant records provided to the insurer or designee
9 utilization review organization by a health care facility.

10 (7) An insurer or its designee review organization shall not
11 affirm the denial of an appeal under subsection (5) unless the
12 appeal is reviewed by a licensed physician.

13 (8) A prior authorization request under this section that has
14 not been certified as urgent by the health care provider is
15 considered granted by the insurer or its designee utilization
16 review organization if the insurer or its designee utilization
17 review organization fails to grant the request, deny the request,
18 or require additional information of the health care provider
19 within 5 business days after the date and time of submission of the
20 prior authorization. If additional information is requested by an
21 insurer or its designee utilization review organization, the prior
22 authorization request is not considered granted if the health care
23 provider fails to submit the additional information within 2
24 business days after the date and time of the request for additional
25 information. If additional information is requested by an insurer
26 or its designee utilization review organization, the prior
27 authorization request is considered to have been granted by the
28 insurer or its designee utilization review organization if the
29 insurer or its designee utilization review organization fails to



1 grant the request, deny the request, or otherwise respond to the
2 request of the health care provider within 5 days after the date
3 and time of the submission of additional information.

4 (9) A prior authorization request under this section that has
5 been certified as urgent by the health care provider is considered
6 granted by the insurer or its designee utilization review
7 organization if the insurer or its designee utilization review
8 organization fails to grant the request, deny the request, or
9 require additional information of the health care provider within 2
10 business days after the date and time of submission of the prior
11 authorization request. If additional information is requested by an
12 insurer or its designee utilization review organization, the prior
13 authorization request is not considered granted if the health care
14 provider fails to submit the additional information within 1
15 business day after the date and time after the request for
16 additional information. If additional information is requested by
17 an insurer or its designee utilization review organization, the
18 prior authorization request is considered to have been granted by
19 the insurer or its designee utilization review organization if the
20 insurer or its designee utilization review organization fails to
21 grant the request, deny the request, or otherwise respond to the
22 request of the health care provider within 2 days after the date
23 and time of the submission of additional information.

24 (10) A prior authorization request granted under this section
25 is valid for not less than 60 calendar days.

26 (11) As used in this section:

27 (a) "Adverse determination" means that term as defined in
28 section 2213.

29 (b) "Evidence-based criteria" means criteria developed using



1 evidence-based standards.

2 (c) "Evidence-based standard" means that term as defined in
3 section 3 of the patient's right to independent review act, 2000 PA
4 251, MCL 550.1903.

5 (d) "Health benefit plan" means an individual or group health
6 insurance policy, an individual or group health maintenance
7 organization contract, or a self-funded plan established or
8 maintained by this state or a local unit of government for its
9 employees. Health benefit plan includes prescription drug benefits.

10 (e) "Health care provider" means any of the following:

11 (i) A health facility as that term is defined in section 2006.

12 (ii) A health professional.

13 (f) "Health professional" means that term as defined in
14 section 2006.

15 (g) "Insurer" means that term as defined in section 2212c.

16 (h) "Licensed physician" means any of the following:

17 (i) A physician licensed to engage in the practice of medicine
18 under part 170 of the public health code, 1978 PA 368, MCL
19 333.17001 to 333.17097.

20 (ii) A physician licensed to engage in the practice of
21 osteopathic medicine and surgery under part 175 of the public
22 health code, 1978 PA 368, MCL 333.17501 to 333.17556.

23 (iii) A physician licensed in another state.

24 (i) "Peer-reviewed" means the clinical review criteria that is
25 approved by a committee comprised of clinicians, including licensed
26 physicians or pharmacists, or both, that meets at regularly-
27 scheduled intervals and evaluates, among other things,
28 pharmaceutical literature or medical literature, or both, and
29 scientific evidence to develop criteria that promotes appropriate,



1 safe, and cost-effective drug utilization.

2 (j) "Prescription drug benefit" means that term as defined in
3 section 2212c.

4 (k) "Prior authorization" means a determination by an insurer
5 or utilization review organization that a requested health care
6 benefit has been reviewed and, based on the information provided,
7 satisfies the insurer or utilization review organization
8 requirements for medical necessity and appropriateness.

9 (l) "Standardized electronic prior authorization transaction
10 process" means a standardized transmission process, identified by
11 the director and aligned with standards that are nationally
12 accepted, to enable prior authorization requests to be accessible,
13 submitted by health care providers, and accepted by insurers or
14 their designee utilization review organizations electronically
15 through secure electronic transmissions with the goal of maximizing
16 administrative simplification, efficiency, and timeliness. The
17 process must require health care providers to supply clinical
18 information under the standardized electronic prior authorization
19 process. Standard electronic prior authorization transaction
20 process does not include a facsimile.

21 (m) "Urgent" means an insured or enrollee is suffering from a
22 health condition that may seriously jeopardize the insured's life,
23 health, or ability to regain maximum function or could subject the
24 insured or enrollee to severe adverse health consequences that
25 cannot be adequately managed without the care or treatment that is
26 the subject of the prior authorization.

27 (n) "Utilization review organization" means that term as
28 defined in section 3 of the patient's right to independent review
29 act, 2000 PA 251, MCL 550.1903.

