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BILL ANALYSIS

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Senate Bill 612 (as introduced 10-29-19)
Sponsor: Senator Curtis S. VanderWall
Committee: Health Policy and Human Services

Date Completed: 1-29-20

CONTENT

The bill would amend Chapter 34 (Disability Insurance Policies) and Chapter 22 (The Insurance Contract) of the Insurance Code to do the following:

- **Require an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy that required a prior authorization with respect to any benefit to make those current prior authorization requirements conspicuously posted and readily accessible on the insurer's public website.**
- **Require prior authorization requirements to be based on peer-reviewed clinical review criteria that met certain requirements.**
- **Require an insurer to make annually statistics regarding prior authorization that contained the information prescribed in the bill.**
- **Prohibit an insurer from implementing a new or amended prior authorization requirement without first updating the insurer's public website to reflect the change.**
- **Require an insurer to notify a health professional of the reasons for a prior authorization denial and specify that an appeal to the denial would have to be reviewed by a physician that met certain requirements.**
- **Require an insurer to ensure that an adverse determination was made by a licensed physician.**
- **Specify the circumstances under which a prior authorization request would have to be considered granted by an insurer.**
- **Modify certain requirements for a program for synchronizing multiple maintenance prescription drugs for an insured or enrollee.**
- **Prohibit an insurer from requiring, among other things, that an insured's or an enrollee's physician participate in a step therapy protocol if the physician considered that the step therapy protocol was not in the insured's or enrollee's best interest.**
- **Require an insurer to adopt a program that promoted the modification of prior authorization requirements based considerations specified in the bill.**

Prior Authorization Requirements; Posting on Website

Under the bill, for an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy, if the policy required a prior authorization with respect to any benefit, the insurer or its designee utilization review organization would have to make any current prior authorization requirement conspicuously posted and readily accessible on the insurer's public website. "Prior authorization" would mean a determination by an insurer or utilization review entity that a requested health care benefit has been reviewed, and based on the information provided, satisfies the insurer or utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care benefit. "Utilization review organization" would mean that term as defined in Section 3 of the

Patient's Right to Independent Review Act: a person that conducts utilization review, other than a health carrier performing a review for its own health plans.

The current prior authorization requirements would have to be described in detail, written in easily understandable language, and readily available to the health provider at the point of care. The prior authorization requirements would have to be based on peer-reviewed clinical review criteria, to which all of the following would apply:

-- The criteria would have to be based on National Specialty Societies Guidelines and those societies' other quality criteria.
-- The criteria would have to take into account the needs of atypical patient populations and diagnoses.
-- The criteria would have to reflect community standards of care.
-- The criteria would have to ensure quality of care and access to needed health care services.
-- The criteria would have to be evidence-based.
-- The criteria would have to be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.
-- The criteria would have to be evaluated and updated, if necessary, at least annually.

In addition, before establishing or substantially or materially altering, written clinical review criteria, an insurer or designee utilization review organization would have to obtain input from actively practicing physicians within the provider network and within the service area where the written clinical review criteria would be employed. The physicians would have to represent major areas of the specialty. The insurer or designee utilization review organization would have to seek input from physicians who were not employees of the insurer or designee utilization review organization. When criteria were developed for a health care service provided by a health professional not licensed to engage in the practice of medicine under Part 170 (Medicine) or Part 175 (Osteopathic Medicine and Surgery) of the Public Health Code, an insurer or a designee utilization review organization would have to seek input from a health professional in the same profession as the health professional providing the health care service.

"Health care provider" would mean any of the following: a) a health facility as that term is defined in Section 2006 of the Insurance Code (a health facility or agency licensed under Article 17 (Facilities and Agencies) of the Public Health Code), or b) a health professional. "Health professional would mean that term as defined in Section 2006 of the Insurance Code: an individual licensed, registered, or otherwise authorized to engage in a health profession under Article 15 (Occupations) of the Public Health Code.

At least annually, an insurer would have to post statistics regarding prior authorization on its public website in a readily accessible format. The categories would have to include all of the following:

-- A list of all benefits that were subject to a prior authorization requirement under the plan.
-- The percentage of prior authorization requests approved during the previous plan year by the insurer with respect to each benefit.
-- The percentage of prior authorization requests denied during the previous plan year by the insurer with respect to each benefit and the top 10 reasons for denial, which would have to include related evidence-based criteria, if applicable.
-- The percentage of denied requests that were appealed, and the percentage of the appealed requests that were overturned, with respect to such benefit.
-- Other information as the Director of the Department of Insurance and Financial Services determined appropriate after consultation with and comment from stakeholders.

Under the bill, if an insurer intended to implement a prior authorization requirement or restriction, or amend an existing one, it would have to ensure that the new or amended requirement was not implemented unless its public website had been updated to reflect the new or amended requirement or restriction. If the insurer intended either to implement a new prior authorization requirement or restriction, or amend an existing one, it would have to provide contracted health care providers with written notice of the new or amended requirement or restriction at least 60 days before the requirement or restriction was implemented.

Denial of Prior Authorization

If an insurer denied a prior authorization, the insurer or its designee utilization review organization, on issuing the denial, would have to notify the health professional of the reasons for the denial and related evidence-based criteria. An appeal of the denial would have to be reviewed by a physician to which all of the following applied:

-- The physician was licensed to practice under Part 170 or Part 175 of the Public Health Code, or was licensed in another state.
-- The physician was board certified or eligible in the same specialty as a health care provider who typically managed the medical condition or disease or provided the health care service.
-- The physician was currently in active practice on a full-time basis in the same specialty as a health care provider who typically managed the medical condition or disease.
-- The physician was knowledgeable of, and had experience providing, the health care services under appeal.
-- The physician could not be employed by an insurer or its designee utilization review organization, be under contract by an insurer or its designee review organization, other than to participate in one or more of the insurer's or utilization review entity's health care provider networks or to perform review of appeals, or otherwise have any financial interest in the outcome of the appeal.
-- The physician had not been involved in making the adverse determination.
-- The physician considered all known clinical aspects of the health care services under review, including a review of all pertinent medical records provided to the insurer or designee utilization review organization by the insured or enrollee's health care provider and any relevant records provided to the insurer or designee utilization review organization by a health care facility.
-- The physician could consider input from a health profession who was licensed in the same profession as the health professional providing health care service.

An insurer or its designee utilization review organization would have to ensure that any adverse determination was made by a physician licensed to engage in the practice of medicine or in the practice of osteopathic medicine and surgery and board certified in the same specialty as the health care provider who typically managed the medical condition or disease or provided the health care service. For a health care service provided by a health professional not licensed to engage in the previously mentioned practices, the physician could consider input from a health professional who was in the same profession as the health professional providing the health care service. The physician would have to make the adverse determination under the clinical direction of one of the insurer's medical directors who was responsible for the provision of health care items and services provided to insureds or enrollees. Medical directors would have to be licensed under Part 170 or 175 of the Public Health Code.

("Adverse determination" would mean that term as defined in Section 2213 of the Insurance Code:

-- A determination by an insurer or its designee utilization review organization that a request for a benefit, on application of any utilization review technique, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
-- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by an insurer or its designee utilization review organization of a covered person's eligibility for coverage from the insurer.
-- A prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit.
-- A rescission of coverage determination.
-- Failure to respond in a timely manner to a request for a determination.)

A prior authorization request that had not been certified as urgent by the health care provider would be considered to have been granted by the insurer or its designee utilization review organization if the insurer failed to grant the request, denied it, or required additional information of the health care provider within 48 hours after the time of the submission. If additional information were requested by an insurer or its designee utilization review organization, a request would not be considered granted if the health care provider failed to submit the additional information within 48 hours after the original request was submitted. If additional information were requested by an insurer or its designee utilization review organization, a prior authorization request would be considered granted by the insurer if the insurer failed to grant the request, denied it, or otherwise responded to the request of the health care provider within 48 hours after the additional information was submitted.

"Urgent" would mean an insured is suffering from a health condition that may jeopardize seriously the insured's life, health, or ability to regain maximum function or could subject the insured to severe pain that cannot be adequately managed without the care or treatment that is the subject of the prior authorization.

A prior authorization request that had been certified as urgent by the health care provider would be considered granted by the insurer or its designee utilization review organization if the insurer failed to grant the request, deny it, or require additional information of the health care provider within 24 hours after the time of the submission. A prior authorization request would have to be valid for one year or until the last day of coverage, whichever occurred first.

Step Therapy Protocol

Under the Code, an insurer that delivers, issues for delivery, or renews in the State an expense-incurred hospital, medical, or surgical group or individual policy or certificate that provides prescription drug coverage, or a health maintenance organization that offers a group or individual contract that provides prescription drug coverage, must provide a program for synchronizing multiple maintenance prescription drugs for an insured or enrollee if criteria prescribed in the Code are met. Instead, under the bill, an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy would have to provide a program for synchronizing multiple maintenance prescription drugs for an insured or enrollee if the prescribed criteria were met.

The Code also requires an insurer or health maintenance organization to apply a prorated daily cost-sharing rate for maintenance prescription drugs that are dispensed by an in-network pharmacy for the purpose of synchronizing the insured's or enrollee's multiple maintenance prescription drugs. The insurer or health maintenance organization also may not reimburse or pay dispensing fee that is prorated, and must pay or reimburse only a dispensing

fee that is based on each maintenance prescription drug dispensed. The bill would delete from these provisions the references to "health maintenance organization".

Under the bill, an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy could not do any of the following:

-- Require the insured's or enrollee's physician to obtain a waiver, exception, or other override before the physician made a determination as described below.
-- Sanction the insured's or enrollee's physician for recommending or issuing a prescription, performing or recommending a procedure, or performing a test that could conflict with the insurer's step therapy protocol.

In addition, an insurer could not require the insured's or the enrollee's physician to participate in a step therapy protocol if the physician considered that the protocol was not in the insured's or enrollee's best interest, including any of the following:

-- The required prescription drug was contraindicated or likely would cause an adverse reaction by or physical or mental harm to the patient.
-- The United States Food and Drug Administration did not approve the required prescription drug.
-- The required prescription drug was expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen.
-- The patient had tried the required prescription drug while under the patient's current or a previous health insurance or health benefit plan, or another prescription drug in the same pharmacological class or with the same mechanism of action and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
-- The patient was stable on a prescription drug selected by the patient's health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

"Step therapy protocol" would mean a protocol or program of an insurer that delivers, issues for delivery, or renews in the State a health insurance policy that established the specific sequence in which prescription drugs for a medical condition are medically appropriate.

The bill also would require an insurer to adopt a transparent program, developed in consultation with health care providers participating with the insurer, that promoted the modification of prior authorization requirements based on the performance of health care providers with respect to adherence to evidence-based medical guidelines and other quality criteria.

MCL 500.3406t et al. Legislative Analyst: Tyler VanHuyse

FISCAL IMPACT

The bill would have no fiscal impact on State or local government.

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