SENATE BILL NO. 612

October 29, 2019, Introduced by Senator VANDERWALL and referred to the Committee on Health Policy and Human Services.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending section 3406t (MCL 500.3406t), as added by 2016 PA 38 and by adding section 2212e.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2212e. (1) For an insurer that delivers, issues for delivery, or renews in this state a health insurance policy, if the health insurance policy requires a prior authorization with respect to any benefit, the insurer or its designee utilization review

organization shall make any current prior authorization requirement conspicuously posted and readily accessible on the insurer's public website. The current prior authorization requirements must 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 must be based on peer-reviewed clinical review criteria. All of the following apply to clinical review criteria under this subsection:

(a) The clinical review criteria must be based on National Specialty Societies Guidelines and those societies' other quality criteria.

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

(c) The clinical review criteria must reflect community standards of care.

(d) The clinical review criteria must ensure quality of care and access to needed health care services.

(e) The clinical review criteria must be evidence-based.

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

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

(h) Before establishing, or substantially or materially altering, written clinical review criteria, an insurer or designee utilization review organization must obtain input from actively practicing physicians within the provider network and within the service area where the written clinical review criteria are to be employed. The physicians described in this subdivision must

represent major areas of the specialty. The insurer or designee utilization review organization shall seek input from physicians who are not employees of the insurer or designee utilization review organization or consultants to the insurer or designee utilization review organization. When criteria are developed for a health care service provided by a health professional not licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556, an insurer or designee utilization review organization must also seek input from a health professional in the same profession as the health professional providing the health care service.

(2) At least annually, an insurer described in subsection (1) shall make statistics regarding prior authorization conspicuously posted and available on the insurer's public website in a readily accessible format. The categories must include all of the following information:

(a) A list of all benefits that are subject to a prior authorization requirement under the plan.

(b) The percentage of prior authorization requests approved during the previous plan year by the insurer with respect to each benefit described in subdivision (a).

(c) The percentage of prior authorization requests denied during the previous plan year by the insurer with respect to each benefit described in subdivision (a) and the top 10 reasons for denial, which must include related evidence-based criteria, if applicable.

(d) The percentage of requests described in subdivision (c)

that were appealed, and the percentage of the appealed requests that were overturned, with respect to such benefit.

(e) Other information as the director determines appropriate after consultation with and comment from stakeholders.

(3) An insurer described in subsection (1) or its designee utilization review organization shall ensure that any adverse determination is made by a physician licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556, and board certified or eligible in the same specialty as the health care provider who typically manages the medical condition or disease or provides the health care service. For a health care service provided by a health professional not licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556, the physician may consider input from a health professional who is in the same profession as the health professional providing the health care service. The physician shall make the adverse determination under the clinical direction of 1 of the insurer's medical directors who is responsible for the provision of health care items and services provided to insureds or enrollees. Medical directors under this subsection must be licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556. As

used in this subsection, "adverse determination" means that term as defined in section 2213.

(4) If an insurer described in subsection (1) intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the insurer shall ensure that the new or amended requirement is not implemented unless the insurer's public website has been updated to reflect the new or amended requirement or restriction. If an insurer described in subsection (1) intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the insurer shall provide contracted health care providers with written notice of the new or amended requirement or restriction not less than 60 days before the requirement or restriction is implemented.

(5) If an insurer described in subsection (1) denies a prior authorization, the insurer or its designee utilization review organization shall, on issuing the denial, notify the health professional of the reasons for the denial and related evidence-based criteria. An appeal of the denial under this subsection must be reviewed by a physician to which all of the following apply:

(a) The physician is licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556, or is licensed in another state.

(b) The physician is board certified or eligible in the same specialty as a health care provider who typically manages the medical condition or disease or provides the health care service.

(c) The physician is currently in active practice on a full-

time basis in the same specialty as a health care provider who typically manages the medical condition or disease.

(d) The physician is knowledgeable of, and has experience providing, the health care services under appeal.

(e) The physician must not be employed by an insurer or its designee utilization review organization, be under contract by an insurer or its designee utilization review organization, other than to participate in 1 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.

(f) The physician has not been involved in making the adverse determination.

(g) The physician considers all known clinical aspects of the health care services under review, including, but not limited to, 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.

(h) The physician may consider input from a health professional who is licensed in the same profession as the health professional providing the health care service.

(6) A prior authorization request that has not been certified as urgent by the health care provider is considered to have been granted by the insurer or its designee utilization review organization if the insurer fails to grant the request, deny the request, or require additional information of the health care provider within 48 hours after the time of the submission. If

additional information is requested by an insurer or its designee utilization review organization, a prior authorization request under this subsection is not considered granted if the health care provider fails to submit the additional information within 48 hours after the time of the original submission of a prior authorization request under this section. If additional information is requested by an insurer or its designee utilization review organization, a prior authorization request is considered to have been granted by the insurer if the insurer fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within 48 hours after the time of the submission of additional information.

(7) A prior authorization request that has been certified as urgent by the health care provider is considered to have been granted by the insurer or its designee utilization review organization if the insurer fails to grant the request, deny the request, or require additional information of the health care provider within 24 hours after the time of the submission.

(8) A prior authorization request granted under this section is valid for 1 year or until the last day of coverage, whichever occurs first.

(9) As used in this section:

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

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

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

(*ii*) A health professional.

(c) "Health professional" means that term as defined in

section 2006.

(d) "Prior authorization" means 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.

(e) "Urgent" means an insured is suffering from a health condition that may seriously jeopardize 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.

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

Sec. 3406t. (1) An insurer that delivers, issues for delivery, or renews in this state ~~an expense-incurred hospital, medical, or surgical group or individual~~ **a health insurance** 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,~~ shall provide a program for synchronizing multiple maintenance prescription drugs for an insured or enrollee if both of the following are met:

(a) The insured or enrollee, the insured's or enrollee's physician, and a pharmacist agree that synchronizing the insured's or enrollee's multiple maintenance prescription drugs for the treatment of a chronic long-term care condition is in the best interests of the insured or enrollee for the management or treatment of a chronic long-term care condition.

(b) The insured's or enrollee's multiple maintenance prescription drugs meet all of the following requirements:

(*i*) Are covered by the **health insurance** policy ~~, certificate, or contract~~ described in this section.

(*ii*) Are used for the management and treatment of a chronic long-term care condition and have authorized refills that remain available to the insured or enrollee.

(*iii*) Except as otherwise provided in this subparagraph, are not controlled substances included in schedules 2 to 5 under sections 7214, 7216, 7218, and 7220 of the public health code, 1978 PA 368, MCL 333.7214, 333.7216, 333.7218, and 333.7220. This subparagraph does not apply to anti-epileptic prescription drugs.

(*iv*) Meet all prior authorization requirements specific to the maintenance prescription drugs at the time of the request to synchronize the insured's or enrollee's multiple maintenance prescription drugs.

(*v*) Are of a formulation that can be effectively split over required short fill periods to achieve synchronization.

(*vi*) Do not have quantity limits or dose optimization criteria or requirements that will be violated when synchronizing the insured's or enrollee's multiple maintenance prescription drugs.

(2) An insurer ~~or health maintenance organization~~ described in subsection (1) shall 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.

(3) An insurer ~~or health maintenance organization~~ described in subsection (1) shall not reimburse or pay any dispensing fee that is prorated. The insurer ~~or health maintenance organization~~ shall

only pay or reimburse a dispensing fee that is based on each maintenance prescription drug dispensed.

(4) An insurer described in subsection (1) shall not do any of the following:

(a) Require the insured's or enrollee's physician to participate in a step therapy protocol if the physician considers that the step therapy protocol is not in the insured's or enrollee's best interest, including, but not limited to, any of the following:

(*i*) The required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient.

(*ii*) The required prescription drug is not approved by the United States Food and Drug Administration.

(*iii*) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen.

(*iv*) The patient has 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 pharmacologic 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.

(*v*) The patient is 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.

(b) Require the insured's or enrollee's physician to obtain a

waiver, exception, or other override before the physician makes a determination under subdivision (a).

(c) Sanction the insured's or enrollee's physician for recommending or issuing a prescription, performing or recommending a procedure, or performing a test that may conflict with the insurer's step therapy protocol.

(5) An insurer described in subsection (1) shall adopt a transparent program, developed in consultation with health care providers participating with that insurer, that promotes the modification of prior authorization requirements based on the performance of the health care providers with respect to adherence to evidence-based medical guidelines and other quality criteria.

(6) As used in this section:

(a) "Health care provider" means that term as defined in section 2212e.

(b) "Prior authorization" means 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.

(c) "Step therapy protocol" means a protocol or program of an insurer described in subsection (1) that establishes the specific sequence in which prescription drugs for a medical condition are medically appropriate.