SUBSTITUTE FOR

SENATE BILL NO. 178

(As amended March 20, 2013)

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

(MCL 500.100 to 500.8302) by adding section 2212c.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 2212C. (1) ON OR BEFORE JANUARY 1, <<2015>>, THE <<WORKGROUP>> SHALL DEVELOP A STANDARD PRIOR AUTHORIZATION METHODOLOGY FOR USE BY PRESCRIBERS TO REQUEST AND RECEIVE PRIOR AUTHORIZATION FROM AN INSURER WHEN A POLICY, CERTIFICATE, OR CONTRACT REQUIRES PRIOR AUTHORIZATION FOR PRESCRIPTION DRUG BENEFITS. THE <<WORKGROUP>> SHALL INCLUDE IN THE STANDARD PRIOR AUTHORIZATION METHODOLOGY THE ABILITY FOR THE PRESCRIBER TO DESIGNATE THE PRIOR AUTHORIZATION REQUEST FOR EXPEDITED REVIEW. IN ORDER TO DESIGNATE A PRIOR AUTHORIZATION REQUEST FOR EXPEDITED REVIEW, THE PRESCRIBER SHALL CERTIFY THAT APPLYING THE 15-DAY STANDARD REVIEW PERIOD MAY

SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE PATIENT OR THE PATIENT'S ABILITY TO REGAIN MAXIMUM FUNCTION.

(2) A PRESCRIPTION DRUG PRIOR AUTHORIZATION WORKGROUP IS CREATED. WITHIN 30 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION, THE DEPARTMENT OF COMMUNITY HEALTH AND THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES SHALL WORK TOGETHER AND APPOINT MEMBERS TO THE WORKGROUP. THE WORKGROUP MUST CONSIST OF A MEMBER WHO REPRESENTS THE DEPARTMENT OF COMMUNITY HEALTH, A MEMBER WHO REPRESENTS THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES, AND MEMBERS WHO REPRESENT INSURERS, PRESCRIBERS, PHARMACISTS, HOSPITALS, AND OTHER STAKEHOLDERS AS DETERMINED NECESSARY BY THE DEPARTMENT OF COMMUNITY HEALTH AND THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES. THE WORKGROUP SHALL APPOINT A CHAIRPERSON FROM AMONG ITS MEMBERS. THE CHAIRPERSON OF THE WORKGROUP SHALL SCHEDULE WORKGROUP MEETINGS. THE DEPARTMENT OF COMMUNITY HEALTH AND THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES SHALL ORGANIZE THE INITIAL MEETING OF THE WORKGROUP AND SHALL PROVIDE ADMINISTRATIVE SUPPORT FOR THE WORKGROUP.

(3)<<

>> IN DEVELOPING THE STANDARD PRIOR AUTHORIZATION METHODOLOGY UNDER SUBSECTION (1), THE << >> WORKGROUP SHALL CONSIDER ALL OF THE FOLLOWING:

(A) EXISTING AND POTENTIAL TECHNOLOGIES THAT COULD BE USED TO TRANSMIT A STANDARD PRIOR AUTHORIZATION REQUEST.

(B) THE NATIONAL STANDARDS PERTAINING TO ELECTRONIC PRIOR AUTHORIZATION DEVELOPED BY THE NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS.

(C) ANY PRIOR AUTHORIZATION FORMS AND METHODOLOGIES USED IN PILOT PROGRAMS IN THIS STATE.

(D) ANY PRIOR AUTHORIZATION FORMS AND METHODOLOGIES DEVELOPED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES.

(4) BEGINNING ON THE EFFECTIVE DATE OF THIS SECTION, AN INSURER MAY SPECIFY IN WRITING THE MATERIALS AND INFORMATION NECESSARY TO CONSTITUTE A PROPERLY COMPLETED STANDARD PRIOR AUTHORIZATION REQUEST WHEN A POLICY, CERTIFICATE, OR CONTRACT

REQUIRES PRIOR AUTHORIZATION FOR PRESCRIPTION DRUG BENEFITS.

(5) IF THE <<WORKGROUP>> DEVELOPS A PAPER FORM AS THE STANDARD PRIOR AUTHORIZATION METHODOLOGY UNDER SUBSECTION (1), THE PAPER FORM SHALL MEET ALL OF THE FOLLOWING REQUIREMENTS:

(A) CONSIST OF NOT MORE THAN 2 PAGES. HOWEVER, AN INSURER MAY REQUEST AND REQUIRE ADDITIONAL INFORMATION BEYOND THE 2-PAGE LIMITATION OF THIS SUBDIVISION, IF THAT INFORMATION IS SPECIFIED IN WRITING BY THE INSURER UNDER SUBSECTION (4). AS USED IN THIS SUBDIVISION, "ADDITIONAL INFORMATION" INCLUDES, BUT IS NOT LIMITED TO, ANY OF THE FOLLOWING:

(*i*) PATIENT CLINICAL INFORMATION INCLUDING, BUT NOT LIMITED TO, DIAGNOSIS, CHART NOTES, LAB INFORMATION, AND GENETIC TESTS.

(*ii*) INFORMATION NECESSARY FOR APPROVAL OF THE PRIOR AUTHORIZATION REQUEST UNDER PLAN CRITERIA.

(*iii*) DRUG SPECIFIC INFORMATION INCLUDING, BUT NOT LIMITED TO, MEDICATION HISTORY, DURATION OF THERAPY, AND TREATMENT USE.

(B) BE ELECTRONICALLY AVAILABLE.

(C) BE ELECTRONICALLY TRANSMISSIBLE, INCLUDING, BUT NOT LIMITED TO, TRANSMISSION BY FACSIMILE OR SIMILAR DEVICE.

(6) BEGINNING JULY 1, <<2016>>, IF AN INSURER USES A PRIOR AUTHORIZATION METHODOLOGY THAT UTILIZES AN INTERNET WEBPAGE, INTERNET WEBPAGE PORTAL, OR SIMILAR ELECTRONIC, INTERNET, AND WEB-BASED SYSTEM, THE PRIOR AUTHORIZATION METHODOLOGY DESCRIBED IN SUBSECTION (5) DOES NOT APPLY. SUBSECTIONS (4), (8), AND (9) APPLY TO A PRIOR AUTHORIZATION METHODOLOGY THAT UTILIZES AN INTERNET WEBPAGE, INTERNET WEBPAGE PORTAL, OR SIMILAR ELECTRONIC, INTERNET, AND WEB-BASED SYSTEM.

(7) BEGINNING JULY 1, <<2016>>, EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (6), AN INSURER SHALL USE THE STANDARD PRIOR AUTHORIZATION METHODOLOGY DEVELOPED UNDER SUBSECTION (1) WHEN A POLICY, CERTIFICATE, OR CONTRACT REQUIRES PRIOR AUTHORIZATION FOR PRESCRIPTION DRUG BENEFITS.

(8) BEGINNING JANUARY 1, <<2016>>, A PRIOR AUTHORIZATION REQUEST THAT HAS NOT BEEN CERTIFIED FOR EXPEDITED REVIEW BY THE PRESCRIBER IS CONSIDERED TO HAVE BEEN GRANTED BY THE INSURER IF THE INSURER FAILS TO GRANT THE REQUEST, DENY THE REQUEST, OR REQUIRE ADDITIONAL INFORMATION OF THE PRESCRIBER WITHIN 15 DAYS AFTER THE DATE AND TIME OF SUBMISSION OF A STANDARD PRIOR AUTHORIZATION REQUEST UNDER THIS SECTION. IF ADDITIONAL INFORMATION IS REQUESTED BY AN INSURER, A PRIOR AUTHORIZATION REQUEST UNDER THIS SUBSECTION IS NOT CONSIDERED GRANTED IF THE PRESCRIBER FAILS TO SUBMIT THE ADDITIONAL INFORMATION WITHIN 15 DAYS AFTER THE DATE AND TIME OF THE ORIGINAL SUBMISSION OF A PROPERLY COMPLETED STANDARD PRIOR AUTHORIZATION REQUEST UNDER THIS SECTION. IF ADDITIONAL INFORMATION IS REQUESTED BY AN INSURER, 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 PRESCRIBER WITHIN 15 DAYS AFTER THE DATE AND TIME OF SUBMISSION OF THE ADDITIONAL INFORMATION. IF ADDITIONAL INFORMATION IS REQUESTED BY AN INSURER, A PRIOR AUTHORIZATION REQUEST UNDER THIS SUBSECTION IS CONSIDERED VOID IF THE PRESCRIBER FAILS TO SUBMIT THE ADDITIONAL INFORMATION WITHIN 21 DAYS AFTER THE DATE AND TIME OF THE ORIGINAL SUBMISSION OF A PROPERLY COMPLETED STANDARD PRIOR AUTHORIZATION REQUEST UNDER THIS SECTION.

(9) BEGINNING JANUARY 1, <<2016>>, A PRIOR AUTHORIZATION REQUEST THAT HAS BEEN CERTIFIED FOR EXPEDITED REVIEW BY THE PRESCRIBER IS CONSIDERED TO HAVE BEEN GRANTED BY THE INSURER IF THE INSURER FAILS TO GRANT THE REQUEST, DENY THE REQUEST, OR REQUIRE ADDITIONAL INFORMATION OF THE PRESCRIBER WITHIN 72 HOURS AFTER THE DATE AND TIME OF SUBMISSION OF A STANDARD PRIOR AUTHORIZATION REQUEST UNDER THIS SECTION. IF ADDITIONAL INFORMATION IS REQUESTED BY AN INSURER, A PRIOR AUTHORIZATION REQUEST UNDER THIS SUBSECTION IS NOT CONSIDERED GRANTED IF THE PRESCRIBER FAILS TO SUBMIT THE ADDITIONAL INFORMATION WITHIN 72 HOURS AFTER THE DATE AND TIME OF THE ORIGINAL SUBMISSION OF A PROPERLY COMPLETED STANDARD PRIOR AUTHORIZATION REQUEST UNDER THIS SECTION. IF ADDITIONAL INFORMATION IS REQUESTED BY AN INSURER, 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 PRESCRIBER WITHIN 72 HOURS AFTER THE DATE AND TIME OF SUBMISSION OF THE ADDITIONAL INFORMATION. IF ADDITIONAL INFORMATION IS REQUESTED BY AN INSURER, A PRIOR AUTHORIZATION REQUEST UNDER THIS SUBSECTION IS CONSIDERED VOID IF THE PRESCRIBER FAILS TO SUBMIT THE ADDITIONAL INFORMATION WITHIN 5 DAYS AFTER THE DATE AND TIME OF THE ORIGINAL SUBMISSION OF A PROPERLY COMPLETED STANDARD PRIOR AUTHORIZATION REQUEST UNDER THIS SECTION.

(10) AS USED IN THIS SECTION:

(A) "INSURER" MEANS ANY OF THE FOLLOWING:

(*i*) AN INSURER ISSUING AN EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY OR CERTIFICATE.

(*ii*) A HEALTH MAINTENANCE ORGANIZATION.

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(*iii*) A HEALTH CARE CORPORATION OPERATING PURSUANT TO THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704.

(*iv*) A THIRD PARTY ADMINISTRATOR OF PRESCRIPTION DRUG BENEFITS.

(B) "PRESCRIBER" MEANS THAT TERM AS DEFINED IN SECTION 17708 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.17708.

(C) "PRESCRIPTION DRUG" MEANS THAT TERM AS DEFINED IN SECTION 17708 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.17708.

(D) "PRESCRIPTION DRUG BENEFIT" MEANS THE RIGHT TO HAVE A PAYMENT MADE BY AN INSURER PURSUANT TO PRESCRIPTION DRUG COVERAGE CONTAINED WITHIN A POLICY, CERTIFICATE, OR CONTRACT DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE.

<<(E) "WORKGROUP" MEANS THE PRESCRIPTION DRUG PRIOR AUTHORIZATION WORKGROUP CREATED UNDER SUBSECTION (2).>>