Legislative Analysis

Mary Ann Cleary, Director
Phone: (517) 373-8080
http://www.house.mi.gov/hfa

STANDARD PRIOR AUTHORIZATION FORM FOR PRESCRIPTION DRUGS

Senate Bill 178 (Substitute S-1 as passed by the Senate)
Senate Bill 179 as passed by the Senate
Sponsor: Sen. Tonya Schuitmaker
House Committee: Health Policy
Senate Committee: Insurance ***(Enacted as Public Acts 30 and 31 of 2013)***

First Analysis (4-22-13)

BRIEF SUMMARY: The bills would require the creation of a single prior authorization form for use by health providers when a patient's health plan requires prior authorization before certain prescription drugs are prescribed.

FISCAL IMPACT: The bills would have a nominal fiscal impact on the Departments of Community Health (DCH) and Insurance and Financial Services (DIFS) resulting from the administrative expenses of organizing, serving on, and staffing the Prescription Drug Prior Authorization Workgroup.

THE APPARENT PROBLEM:

In an effort to contain health care costs, most, if not all, health insurers require a physician or other lawfully authorized prescriber to obtain prior authorization before prescribing certain medications. Generally speaking, these are high cost prescription drugs or drugs that are not on a health plan's drug formulary.

A drug formulary is a list of prescription drugs that a health plan will pay for, in whole or in part, as a covered benefit. If a drug is not on the health plan's formulary, patients will either incur higher co-pays than for a similar drug that is on the formulary or pay the entire cost out of pocket. Insurers generally will cover non-formulary drugs under certain conditions, such as when patients have allergic or adverse reactions to a similar drug on its formulary. However, a physician must first seek prior authorization from the health plan before writing the prescription.

The problem is that there are about 150 different versions of a prior authorization form currently in use by insurance carriers offering health plans in Michigan. The forms can vary in length, usually being several pages long. Even if the forms contain similar questions or ask for similar information, those questions appear in different places and with different wording from form to form. The result is that physician offices are finding it increasingly time consuming and expensive to fill out these forms on behalf of their patients. One doctor reported that his practice had to hire two full time employees per physician just to fill out paperwork. Physicians complain that the excessive paperwork requirements drive up the cost to provide quality healthcare, delay patients' access to

necessary medications, and take them away from doing what they need to be doing—spending more time with patients.

To address similar concerns, some states have recently adopted a uniform prior authorization form. It has been suggested that Michigan do the same.

THE CONTENT OF THE BILLS:

Senate Bill 178 would add the new requirements to the Insurance Code (MCL 500.2212c) to apply to commercial insurance companies and HMOs. Senate Bill 179 would amend the Nonprofit Health Care Corporation Reform Act to apply the provisions of Senate Bill 178 to Blue Cross Blue Shield of Michigan (MCL 550.1402d).

Senate Bill 178 would do the following:

- Beginning July 1, 2016, require an insurer to use the standard prior authorization methodology when a policy, certificate, or contract requires prior authorization for prescription drug benefits. "Insurer" would mean a commercial insurance company, HMO, BCBSM, or a third party administrator of prescription drug benefits.

- Enable a prescriber (e.g., physician or dentist) to request an expedited review on the standardized form if he or she certified that the 15-day standard review period for prior authorization may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

- Create a Prescription Drug Prior Authorization Workgroup. Within 30 days of the bill's effective date, the Departments of Community Health (DCH) and Insurance and Financial Services (DIFS) would be required to work together and appoint members to a workgroup that would include a representative of each of those two departments and also members representing insurance companies, prescribers, pharmacists, hospitals, and other stakeholders. The workgroup would have to develop a standard prior authorization methodology on or before January 1, 2015.

- In developing the standardized form, require the workgroup to take into consideration existing and potential technologies for transmitting a standard prior authorization request, national standards pertaining to electronic prior authorization developed by the National Council for Prescription Drug Programs, prior authorization forms and methodologies used in pilot programs in the state, and any prior authorization forms and methodologies developed by the federal Centers for Medicaid and Medicare Services.

- Beginning January 1, 2016, consider a prior authorization request that had been certified for expedited review to be granted if the insurer failed to grant it, deny it,

or require additional information within 72 hours of submission or within 15 days of submission for a request not certified for expedited review.

- If the workgroup developed a paper form as the standard, then require that the paper form be limited to no more than two pages, with some exceptions for "additional information" (as described in the bill); and be electronically available and transmissible (e.g., by fax or similar device). This methodology would not apply to a prior authorization methodology using an Internet, web-based system.

- Define "prescriber" to mean that term as defined in the Public Health Code. [Section 17708 defines the term to mean a licensed dentist, physician (MD or DO), podiatrist, optometrist certified under Part 174 of the code to administer and prescribe therapeutic pharmaceutical agents, veterinarian, or another licensed health professional acting under the delegation and using, recording, or otherwise indicating the name of the delegating licensed physician.]

Senate Bill 179 would specify that the provisions of Senate Bill 178 would also apply to Blue Cross Blue Shield of Michigan. The bill is tie-barred to Senate Bill 178 and House Bill 4275, meaning that the bill cannot be enacted unless either of the other two bills is also enacted.

HOUSE COMMITTEE ACTION:

The bills were reported from the House Health Policy Committee without amendment.

BACKGROUND INFORMATION:

The bills are nearly identical to House Bills 4274 and 4275, which were previously passed by the House of Representatives.

On March 17, the Office of Financial and Insurance Regulation (OFIR) became the Department of Financial and Insurance Services (DIFS).

ARGUMENTS:

For:

Not all prescription drugs require the approval of a patient's health insurer before a doctor or other prescriber writes a prescription. Generally speaking, prior authorization is reserved for drugs that are not on a health plan's formulary, ones that are very expensive, or drugs for which a higher than typical dosage is required. When a patient's health plan does require a physician or other prescriber to obtain prior authorization, Senate Bills 178 and 179 would streamline the process. The prior authorization form and methodology created under the bills is limited to prescription drugs and would not pertain to other situations in which an insurance company may require prior authorization, such as before ordering an MRI.

Within the health plans they offer, insurers would still retain discretion over which prescription drugs would require prior authorization. Insurance company representatives would also be included in the list of stakeholders that would be involved in the workgroup developing the standardized form. The 15-day standard review period, and the 72-hour period for an expedited request, take effect six months before insurers are required to only use the standardized form created under the bill. This allows insurers a buffer period to adjust to the new review periods while responding to requests already in the pipeline, so to speak, and to requests still submitted via older prior authorization forms.

The effective dates for various provisions also give adequate time for the workgroup to receive input and develop a standardized form, for insurers to educate their panel members on how to use the new form and to create a web-based prior authorization system (if they wish to), and for the Department of Insurance and Financial Services to implement any necessary regulatory process related to use of the new prior authorization form. Therefore, the legislation should not be overly burdensome or disruptive to insurers doing business in the state or to state regulators.

Having a standard prior authorization form that can be used for any insurance plan is expected to provide patients timely access to necessary medications, quicker approval for expedited requests, and reduced costs to physician and other prescriber practices. Most important, a standardized form should free up time currently spent by physicians and dentists filling out paperwork that could be used instead on patients. Pharmacists will also benefit from a single, standardized form as their time coordinating a patient's pharmacy benefits coverage with a doctor's prescription order will be reduced.

Response:

Though two states, Minnesota and Maryland, have adopted legislation requiring implementation of a standardized prior authorization form, it is still too soon to know how it is working. Many other states have been considering similar legislation, but either they have not yet adopted it or the implementation dates are a year or more away. Thus, this is new territory, so to speak, and should be done carefully and thoughtfully so as to create unintended consequences. For instance, if the form limits specific information that an insurer feels it needs, a delay or denial of authorization could result. The ensuing appeals process and back-and-forth communication between the insurer and prescriber could be time consuming. Further, it has been noted by insurers that any form adopted under the bills would most likely need CMS approval (the federal agency overseeing the Medicaid and Medicare programs) to ensure acceptance by either Medicaid or Medicare plans.

Rebuttal:

Senate Bill 178 as passed by the Senate addressed the concern regarding designing a form that would meet CMS approval by including the Department of Community Health, which administers the state Medicaid program, in the workgroup membership. The bill also allows any health insurer an opportunity to submit input in writing. Though the bill does not specify to whom the input should be directed, it is reasonable to assume the input would be directed to the workgroup or the Department of Insurance and Financial Services, or both.

POSITIONS:

Blue Cross Blue Shield of Michigan indicated support for the bills. (4-16-13)

The Michigan Academy of Pediatrics indicated support for the bills. (4-16-13)

The Michigan Academy of Family Physicians indicated support for the bills. (4-16-13)

The Michigan Primary Care Association indicated support for the bills. (4-16-13)

The Michigan Podiatric Medical Association indicated support for the bills. (4-16-13)

Legislative Analyst: Susan Stutzky
Fiscal Analyst: Paul Holland
Susan Frey

■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.