Legislative Analysis

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STANDARD PRIOR AUTHORIZATION METHODOLOGY

House Bill 4274 (reported from committee without amendment
House Bill 4275 (Substitute H-1)
Sponsor: Rep. Gail Haines
Committee: Health Policy

First Analysis (3-14-13)

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: House Bill 4275 (H-1) and House Bill 4274 would have a minor negative fiscal impact on the Office of Financial and Insurance Regulation (OFIR) resulting from administrative expenses of organizing and staffing the workgroup and developing the standard prior authorization methodology.

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 their 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:

The bills would require the commissioner of the Office of Financial and Insurance Regulation (OFIR) to develop a standard prior authorization methodology for use by prescribers to request and receive prior authorization from insurers when a health plan requires prior authorization for prescription drug benefits. The methodology would have to be developed on or before January 1, 2014, and include the ability for a prescriber to designate the request for an expedited review.

House Bill 4275 would add a new section to the Insurance Code (MCL 500.2212c). House Bill 4274 would add a new section to the Nonprofit Health Care Corporation Reform Act, which pertains to Blue Cross Blue Shield of Michigan (MCL 550.1402d).

House Bill 4275 would do the following:

- Require an insurer to use the standard prior authorization methodology beginning July 1, 2015. "Insurer" would mean a commercial insurance company, HMO, BCBSM, or a third party administrator of prescription drug benefits.

- Require the commissioner to appoint a workgroup, within 30 days of the bill's effective date, to assist in the development of the standard prior authorization methodology. Members would represent insurance companies, prescribers, pharmacists, hospitals, the Department of Community Health, and other stakeholders.

- Require the commissioner to hold at least one public hearing to gather input from interested parties.

- Require the commissioner and 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.

- If the commissioner 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.

- Beginning January 1, 2015, consider a prior authorization request that had not been certified for expedited review to have been granted by the insurer if the

insurer fails to grant the request, deny the request, or require additional information within 15 days after the date and time the request was submitted.

- Consider a prior authorization request 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.

- 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.)

House Bill 4274 would specify that the provisions of House Bill 4275 would also apply to Blue Cross Blue Shield of Michigan. The bill is tie-barred to House Bill 4275, meaning that the bill cannot be enacted unless House Bill 4275 is also enacted.

BACKGROUND INFORMATION:

The bills are nearly identical to Senate Bills 429 and 430 of last session. Those bills were passed by the Senate.

On March 17, the Office of Financial and Insurance Regulation (OFIR) will become 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 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, House Bills 4274 and 4275 would streamline the process. The prior authorization form and methodology created under the bills 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. Therefore, the legislation should not be overly burdensome or disruptive to insurers doing business in the state.

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 practices. Most importantly, a standardized form should free up time currently spent by physicians filling out paperwork

that could be used instead to spend more time with 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.

POSITIONS:

Representatives of the following associations or organizations testified and submitted written testimony in support of the bills on 2-26-13:

Michigan State Medical Society
Michigan Association Health Plans (though the Association expressed some concerns)
Michigan Osteopathic Association testified in support of the bills
Michigan Academy of Family Physicians testified in support of the bills
A representative of Express testified in opposition to the bills

The following associations or organizations indicated support for the bills:

Pfizer (2-26-13 and 3-5-13)
Michigan Health and Hospital Association (3-5-13)
Michigan Academy of Pediatrics (2-26-13)
Takeda Pharmaceuticals (2-26-13 and 3-5-13)
Michigan Optometric Association (3-5-13)
Michigan Primary Care Association (3-5-13)
Michigan Podiatric Medical Association (2-26-13)
UAW - Retiree Medical Benefit Trust (2-26-13)
Michigan Pharmacist Association (2-26-13)

Blue Cross Blue Shield of Michigan indicated a neutral position on the bills. (2-26-13)

The Office of Financial and Insurance Regulation indicated opposition to the bills. (3-5-13)

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■ 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.