Legislative Analysis

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STANDARD PRIOR AUTHORIZATION METHODOLOGY

House Bills 4274 and 4275
Sponsor: Rep. Gail Haines
Committee: Health Policy

Complete to 2-25-13

A SUMMARY OF HOUSE BILLS 4274 AND 4275 AS INTRODUCED 2-19-13

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, and other stakeholders.

- Require the commissioner to hold at least one public hearing.

- Require the commissioner and workgroup to take into consideration existing and potential technologies for transmitting a standard prior authorization request, national standards 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.

- 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.

FISCAL IMPACT:

A fiscal analysis is in process.

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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.