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BILL ANALYSIS

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Senate Bills 178 and 179 (as introduced 2-12-13)
Sponsor: Senator Tonya Schuitmaker
Committee: Insurance

Date Completed: 3-1-13

CONTENT

Senate Bill 178 would add Section 2212c to the Insurance Code to do the following:

- **Require the Commissioner of the Office of Financial and Insurance Regulation (OFIR), by January 1, 2014, to develop a standard methodology that a prescriber would have to use to request and receive prior authorization for prescription drug benefits, when required by an insurer.**
- **Require the Commissioner to appoint a workgroup to assist in development of the methodology.**
- **Require the methodology to enable a prescriber to designate a prior authorization request for expedited review.**
- **Require an insurer to use the standard methodology beginning July 1, 2015.**
- **Provide that a prior authorization request that was not certified for expedited review would be considered granted if the insurer failed to grant or deny it or require additional information within 15 days, beginning January 1, 2015.**
- **Provide that an expedited request would be considered granted if the insurer failed to grant or deny it or require additional information within 72 hours, beginning January 1, 2015.**

Senate Bill 179 would amend the Nonprofit Health Care Corporation Reform Act to provide that Section 2212c of the Insurance Code would apply to Blue Cross Blue Shield of Michigan (BCBSM).

Senate Bill 179 is tie-barred to Senate Bill 178, which is described below in further detail.

Under the bill, by January 1, 2014, the OFIR Commissioner would have to 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 required prior authorization for prescription drug benefits.

("Insurer" would mean an insurer issuing an expense-incurred hospital, medical, or surgical policy or certificate; a health maintenance organization; BCBSM; or a third-party administrator of prescription drug benefits.

"Prescriber" would mean that term as defined in the Public Health Code, i.e., a licensed dentist, physician optometrist, veterinarian, or other licensed health professional acting under the delegation of a licensed doctor of medicine or osteopathic medicine and surgery.

"Prescription drug benefit" would mean 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 Michigan.)

The Commissioner would have to include in the methodology the ability for the prescriber to designate the request for expedited review. In order to designate a request for expedited review, the prescriber would have to certify that applying the 15-day standard review period would seriously jeopardize the patient's life, health, or ability to regain maximum function.

Within 30 days after the bill took effect, the Commissioner would have to appoint a workgroup to assist in the development of the standard prior authorization methodology. The workgroup members would have to represent insurers, prescribers, pharmacists, hospitals, and other stakeholders in the methodology's development.

In developing the standard methodology, the Commissioner would have to hold at least one public hearing to gather input from interested parties. The Commissioner and the workgroup would have to consider all of the following:

-- Existing and potential technologies that could be used to transmit a standard prior authorization request.
-- The national standards pertaining to electronic prior authorization developed by the National Council for Prescription Drug Programs.
-- Any prior authorization forms and methodologies used in pilot programs in Michigan.
-- Any prior authorization forms and methodologies developed by the Federal Centers for Medicare and Medicaid Services.

Beginning on the bill's effective date, an insurer could specify in writing the materials and information necessary to constitute a properly completed standard prior authorization request when a policy, certificate, or contract required prior authorization for prescription drug benefits.

If the Commissioner developed a paper form as the standard methodology, the form would have to be electronically available and electronically transmissible, including by facsimile or similar device. The paper form could not consist of more than two pages. An insurer could request and require additional information beyond the two-page limitation, however, if the insurer specified that information in writing. "Additional information" would include the following:

-- Patient clinical information, including diagnosis, chart notes, lab information, and genetic tests.
-- Information necessary for approval of the prior authorization request under plan criteria.
-- Drug-specific information, including medication history, duration of therapy, and treatment use.

Beginning July 1, 2015, if an insurer used a prior authorization methodology that used an internet webpage or webpage portal, or similar electronic, internet, and web-based system, the standard paper form would not apply. Such a methodology would be subject to the bill's requirement that an insurer specify in writing the materials and information necessary for a properly completed prior authorization request, as well as provisions regarding the timeline for responding to a request (described below).

Beginning July 1, 2015, except as provided for an electronic, internet, or web-based system, an insurer would have to use the standard prior authorization methodology developed under the bill when a policy, certificate, or contract required it.

Beginning January 1, 2015, a prior authorization request that the prescriber had not certified for expedited review would be considered granted if the insurer failed to grant or deny the request or require additional information within 15 days after the date and time the request was submitted. If the insurer required additional information, a request would not be considered granted if the prescriber failed to submit the information within 15 days after the date and time of the original submission of a properly completed request. A request would be considered granted if the insurer failed to grant or deny it, or otherwise respond, within 15 days after the prescriber submitted the additional information. A request would be considered void if the prescriber failed to submit the additional information within 21 days after the original request submission.

Beginning January 1, 2015, a prior authorization request that the prescriber certified for expedited review would be considered granted if the insurer failed to grant or deny it, or require additional information of the prescriber, within 72 hours after the request was submitted. If the insurer required additional information, a request would not be considered granted if the prescriber failed to submit the information within 72 hours after the properly completed request was submitted. A request would be considered granted if the insurer failed to grant, deny, or otherwise respond within 72 hours after the additional information was submitted. The request would be considered void if the prescriber failed to submit the additional information within five days after submission of the original properly completed request.

Proposed MCL 500.2212c (S.B. 178)
Proposed MCL 550.1402d (S.B. 179)

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

A standard prior authorization form could reduce administrative costs for insurers. This could lead to marginally lower costs for insurance, which would result in a small, indeterminate reduction in employee benefit costs for State and local government.

The bills also would have a minor, but negative direct fiscal impact on the Office of Financial and Insurance Regulation. Under the bills, the Commissioner would be required to form a workgroup to assist in the development of a standard prior authorization methodology. This workgroup would likely be supported by existing OFIR resources.

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