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Public Acts of 2013
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STATE OF MICHIGAN
97TH LEGISLATURE
REGULAR SESSION OF 2013

Introduced by Senator Schuitmaker

ENROLLED SENATE BILL No. 178

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act," (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.

(*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).

Carol Morey Viventi

Secretary of the Senate

Clerk of the House of Representatives

Approved .....

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Governor