Legislative Analysis

Phone: (517) 373-8080
http://www.house.mi.gov/hfa

Analysis available at
http://www.legislature.mi.gov

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

House Bill 4935 as enacted
Public Act 276 of 2016
Sponsor: Rep. Tom Leonard
House Committee: Insurance
Senate Committee: Insurance
Complete to 1-31-17

BRIEF SUMMARY: This bill accelerated the prior authorization process for drug coverage to 24 hours for an expedited review and 72 hours for a typical review. Other changes include an expansion of the term "adverse determination" and increased representation of policyholders on insurers' governing boards. It has an effective date of July 1, 2016.

FISCAL IMPACT: The bill, along with other related bills, HB 4933 and 4934, would have a neutral fiscal impact on the Department of Insurance and Financial Services (DIFS). The bills would stimulate higher expenditures, within the short-term, to the extent that DIFS would prepare and publish departmental bulletins and declaratory rulings to provide guidance pertaining to the applicability and interpretation of statutory revisions to the Insurance Code, in addition to training relevant regulatory and enforcement staff on the aspects and effects of the revisions under the bills. However, these expenditures would be sufficiently offset with revenue generated by the annual regulatory fee determined by DIFS, subject to a statutory formula, and levied on insurers (totaling approximately $18.2 million during FY 15).

THE APPARENT PROBLEM:

The current process for obtaining prior authorization for drug coverage is said to be inefficient and confusing. It can be used to restrict access to certain drugs and treatments to policyholders. Even when the third-party payer has not explicitly denied coverage over a drug, the prior authorization may take so long that the policyholder and insurer may become distracted and give up pursuit of the drug.

THE CONTENT OF THE BILL:

This bill would amend 107 sections of the Insurance Code of 1956, on topics ranging from coverage of out-of-wedlock children and illegal activities to the director of the Department of Insurance and Financial Services' ability to reject unfair insurance policies.

One major change made by the bill relates to ***prior authorization*** requests for prescription drugs. Section 3406o of the bill would require an insurer to notify the policyholder and physician whether the insurer will cover a nonformulary alternative within a set time. The insurer must notify the policyholder within 24 hours after receiving the request in cases of expedited review for exigent circumstances, and within 72 hours in nonexigent

circumstances. Exigent circumstances exist when the policyholder is suffering from a health condition that may seriously jeopardize his or her life or health, or if the policyholder is currently undergoing that treatment.

Throughout the bill, "a ***nonprofit dental care corporation***" operating under the applicable statute is also added to the list of authorized insurers, with all of the same responsibilities and protections.

Definitions

- Sec. 607: Defines ***group disability insurance*** as voluntary disability insurance covering two or more people under a master policy issued to a corporation or other entity. Sections 3401A-3402B further describe which insurers may offer group disability insurance, allowable statements to be included in the policy, and coordination of benefits.

Insurance Contracts

- Sec. 2212a: Details the required ***format*** of an insurance policy, including font size and style, line length, page numbering, and incorporation by reference, and prohibition thereof, with respect to other documents.

- Sec. 2213: Amends the timing of final determinations in the ***grievance process***. Currently, a final determination must be issued within 35 days of the filing of the grievance; the bill would amend that to 30 days if following a preservice grievance, and 60 days if following a postservice grievance. If the process is composed of two parts, the first part could be no longer than 15 days for a preservice grievance and 30 days for a postservice grievance.

- Sec. 2213: Replaces the definition of an ***adverse determination***, which currently refers to either the denial of care or the failure to respond by the insurer, with any of the following definitions:
    - A determination that a request for a benefit does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.
    - A determination that the requested treatment or procedure is experimental, and the benefit is therefore denied, reduced, or terminated.
    - A determination that the patient is ineligible or only partially eligible for coverage by the insurer.
    - A prospective or retrospective review that denies, reduces, or terminates or fails to provide or make payment for a benefit.
    - A rescission of coverage determination.
    - (As before) failure of the insurer to respond in a timely manner to a request for determination.

- Sec. 2236: Details the ways in which an insurer may deliver an insurance form or notice: either by ensuring that a hard copy the form is actually received, sending the

form electronically or, if requested, delivering a hard copy of an electronically-delivered form.

Individual Disability Coverage

- Sec. 3402C: Defines ***family expense insurance*** as accident and health insurance which covers the main policyholder (head of family for the purposes of the account), a spouse, and dependent children.

- Sec. 3402D: Describes ***blanket disability insurance*** as a policy issued to an entity (e.g. employer, school or university, volunteer group, etc.) which covers all members of that entity.

- Sec. 3403: Clarifies that an insurer whose policy includes ***dependent coverage*** may not deny the policyholder's child's enrollment because the child was born out of wedlock, is not claimed as a dependent on the policyholder's federal income tax return, or does not live with the policyholder or in the insurer's service area.

- Sec. 3452: Allows an insurer to state in its disability insurance policy that ***an illegal occupation or criminal activity*** is not covered by the policy; specifically, if the insurer was engaged in willful criminal activity such as operating a motor vehicle while intoxicated or operating a meth lab, and is injured, the insurer is not liable for any loss.

Health Maintenance Organizations (HMOs)

- Sec. 3511: Requires a health maintenance organization to include at least one individual who represents the organization's membership in its ***governing body***. When the organization is under contract with the state to provide medical services, it must either its governing board must be made up of at least 1/3 representatives of membership, or establish a consumer advisory council, which must include at least one enrollee, one family member of an enrollee, and one consumer advocate.

This bill had been tie-barred to House Bills 4933 and 4934, and so could not take effect if those two were also enacted. Those two bills were enacted as Public Acts 274 and 275 of 2016.

ARGUMENTS:

For:

Proponents argue that this bill would improve the current prior authorization process and reduce inefficiencies. By receiving a timely answer about drug coverage, a patient would be better able to make informed medical decisions, either by appealing the adverse determination or consulting with his doctor about other options.

Legislative Analyst: Jenny McInerney
Fiscal Analyst: Marcus Coffin
Paul B.A. Holland

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