# Legislative Analysis

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**HEALTH INSURER PREAUTHORIZATIONS**

**Senate Bill 247 (S-3) as passed by the Senate**
**Sponsor: Sen. Curtis S. VanderWall**
**House Committee: Health Policy**
**Senate Committee: Health Policy and Human Services**
**Complete to 3-3-22**

**SUMMARY:**

Senate Bill 247 would amend the Insurance Code to require health insurers and their utilization review entities to make available and begin using an internet-based process for benefit preauthorizations by January 1, 2023. A list of benefits subject to preauthorization, and preauthorization requirements, would have to be made available on the web. Preauthorization requirements would have to be based on peer-reviewed clinical review criteria meeting requirements described in the bill. The bill also would provide certain criteria and procedures for preauthorization determinations and appeals, provide time limits, and require insurers and the Department of Insurance and Financial Services (DIFS) to make and publish certain reports.

Under the bill, if an insurer delivers, issues for delivery, renews, or administers a ***health benefit plan*** in Michigan that requires a ***prior authorization*** for any benefit, the insurer (or its designee utilization review organization) would have to make available a ***standardized electronic prior authorization request transaction process*** using an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system by January 1, 2023.

> ***Health benefit plan*** would mean means an individual or group health insurance policy, an individual or group health maintenance organization contract, or a self-funded plan established or maintained by this state or a local unit of government for its employees. The term would include prescription drug benefits.
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> ***Prior authorization*** would mean a determination by an insurer or utilization review organization that a requested health care benefit has been reviewed and, based on the information provided, satisfies the insurer or utilization review organization requirements for medical necessity and appropriateness.
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> ***Standardized electronic prior authorization transaction process*** would mean a standardized transmission process, identified by the director of DIFS and aligned with standards that are nationally accepted, to enable prior authorization requests to be accessible, submitted by health care providers, and accepted by insurers (or their designee utilization review organizations) electronically through secure electronic transmissions with the goal of maximizing administrative simplification, efficiency, and timeliness. The process would have to allow health care providers to supply clinical information under the standardized electronic prior authorization process. Standard electronic prior authorization transaction process would not include a facsimile (fax).

Beginning January 1, 2023, the insurer (or its designee utilization review organization) and the health professional would have to perform a prior authorization using only a standard electronic

prior authorization transaction process that allows the transmission of clinical information, unless the health professional cannot use the standard electronic prior authorization transaction process due to a temporary technological or electrical failure.

The insurer also would have to make available on its public website in a readily accessible format a list of all benefits that are subject to a prior authorization under the health benefit plan.

Current requirements

Current prior authorization requirements would have to be described in detail and written in easily understandable language. An insurer (or its designee utilization review organization) would have to make any current prior authorization requirements and restrictions (including the written clinical review criteria) readily accessible and conspicuously posted on its website to insureds, enrollees, health care professionals, and health care providers. Content published by a third party and licensed for use could be made available through a secure, password-protected website if the access requirements do not unreasonably restrict access to the content.

The prior authorization requirements would have to be based on ***peer-reviewed*** clinical review criteria, and all of the following would apply to the clinical review criteria:

- Except as described below, the criteria must be developed either by a professional medical specialty society or by an entity that works directly with clinicians to develop the criteria and does not receive direct payments based on the outcome of the clinical care decision.
- The criteria must take into account the needs of atypical patient populations and diagnoses.
- The criteria must ensure quality of care and access to needed health care services.
- The criteria must be evidence-based.
- The criteria must be sufficiently flexible to allow deviations from norms on a case-by-case basis when justified.
- The criteria must be evaluated and updated, if necessary, at least annually.
- For coverage other than prescription drug benefit coverage, before establishing or substantially altering its own written clinical review criteria, an insurer (or its designee utilization review organization) must obtain input from actively practicing licensed physicians representing major areas of the specialty.
- For coverage of a prescription drug benefit, before establishing or substantially altering its own clinical review criteria, an insurer (or its designee utilization review organization) must obtain input from actively practicing licensed pharmacists or actively practicing licensed physicians.
- If criteria are developed for a health care service provided by a health professional who is not licensed to engage in the practice of medicine or osteopathic medicine under the Public Health Code, an insurer or designee utilization review organization must also seek input from a health professional in the same profession as the health professional providing the health care service.

  ***Peer-reviewed*** would mean the clinical review criteria approved by a committee composed of clinicians, including licensed physicians or licensed pharmacists, or both, that meets at regularly scheduled intervals and evaluates, among other things, pharmaceutical literature or medical literature, or both, and scientific evidence to develop criteria promoting appropriate, safe, and cost-effective drug utilization.

New or amended requirements

If an insurer implemented a new prior authorization requirement or restriction with respect to any benefit under a health benefit plan, or amended an existing one, the insurer would have to ensure that the new or amended requirement or restriction is posted on its public website before its implementation.

For a benefit that does not involve coverage of a prescription drug, an insurer would have to notify contracted health care providers through its provider portal of the new or amended requirement or restriction at least 60 days before its implementation.

For coverage of a prescription drug, the insurer would have to make available on its website or notify contracted health care providers through its provider portal of the new or amended requirement or restriction at least 45 days before its implementation unless any of the following apply:

- The United States Food and Drug Administration (FDA) has done any of the following:
  - Issued a statement that calls into question the clinical safety of the drug.
  - Required the manufacturers to conduct postmarket safety studies and clinical trials after the approval of the drug.
  - Issued any drug safety-related labeling changes.
  - Required the manufacturers to implement special risk management programs.
- The drug receives a new FDA approval and has become available.
- The FDA has approved expanded use of the drug.

Modification of requirements

An insurer would have to adopt a program, developed in consultation with health care providers participating with the insurer, that promotes the modification of prior authorization requirements of certain prescription drugs, medical care, or related benefits, based on any of the following:

- The performance of health care providers with respect to adherence to nationally recognized evidence-based medical guidelines, appropriateness, efficiency, and other quality criteria.
- Involvement of contracted health care providers with an insurer to participate in a financial risk-sharing payment plan that includes downside risk.
- Health provider specialty, experience, or other factors.

Requests and determinations

The initial review of information submitted in support of a request for prior authorization could be conducted and approved by a health professional.

An adverse determination regarding a request for prior authorization for a benefit other than a prescription drug would have to be made by a licensed physician. For an adverse determination of a health care service provided by a health professional who is not a licensed physician, the licensed physician could consider input from a health professional in the same profession. The licensed physician would have to make the adverse determination under the general direction of the insurer's medical director who oversees the utilization management program.

An adverse determination regarding a request for prior authorization for a prescription drug would have to be made by a licensed pharmacist or licensed physician. The licensed pharmacist

or licensed physician would have to make the adverse determination under the general direction of the insurer's medical director who oversees the utilization management program.

Medical directors under the above provisions would have to be licensed to engage in the practice of medicine under Part 170 or 175 of the Public Health Code.

If an insurer denies a prior authorization, the insurer (or its designee utilization review organization) would have to notify the health professional and insured or enrollee of all of the following on issuing a benefit denial:

- The reasons for the denial and related evidence-based criteria.
- The right to appeal the adverse determination.
- Instructions on how to file the appeal.
- Additional documentation necessary to support the appeal.

Except as described below, an appeal of the denial under the above provisions would have to be reviewed by a health professional to whom all of the following apply:

- The health professional does not have a direct financial stake in the outcome of the appeal.
- The health professional has not been involved in making the adverse determination.
- The health professional must consider all known clinical aspects of the health care services under review, including at least a review of all pertinent medical records provided to the insurer or designee utilization review organization by the insured or enrollee's health care provider and any relevant records provided to the insurer or designee utilization review organization by a health care facility.
- The health professional may consider input from a health professional who is licensed in the same profession as the health professional providing the health care service or a licensed pharmacist if the adverse decision is regarding a prescription drug.

An insurer (or its designee utilization review organization) could not affirm the denial of an appeal described above unless the appeal was reviewed by a licensed physician who is board certified or eligible in the same specialty as a health care provider who typically manages the medical condition or disease or provides the health care service. However, if an insurer (or its designee utilization review organization) cannot identify a licensed physician who meets these requirements without exceeding the applicable time limits described below, the insurer (or its designee utilization review organization) could utilize a licensed physician in a similar specialty as considered appropriate, as determined by the insurer (or its designee utilization review organization).

Time limits

Beginning January 1, 2023, through December 31, 2023, a prior authorization request under the bill that has not been certified as ***urgent*** by the health care provider would be considered granted if the insurer (or its designee utilization review organization) fails to grant the request, deny the request, or require additional information of the health care provider within nine calendar days after the date and time of submission of the prior authorization.

***Urgent*** would mean that an insured or enrollee is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or could subject the insured or enrollee to severe adverse health consequences

that cannot be adequately managed without the care or treatment that is the subject of the prior authorization.

After December 31, 2023, a prior authorization request that has not been certified as urgent by the health care provider would be considered granted if the insurer (or its designee utilization review organization) fails to grant the request, deny the request, or require additional information of the health care provider within seven calendar days after the date and time of submission of the prior authorization.

Beginning January 1, 2023, through December 31, 2023, if additional information were requested by an insurer (or its designee utilization review organization), the prior authorization request would be considered to have been granted if the insurer (or its designee utilization review organization) fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within nine calendar days after the date and time of the submission of additional information.

After December 31, 2023, if additional information were requested by an insurer (or its designee utilization review organization), the prior authorization request would be considered to have been granted if the insurer (or its designee utilization review organization) fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within seven calendar days after the date and time of the submission of additional information.

Beginning January 1, 2023, a prior authorization that has been certified as urgent by the health care provider would be considered granted if the insurer (or its designee utilization review organization) fails to grant the request, deny the request, or require additional information of the health care provider within 72 hours after the date and time of submission of the prior authorization request. If additional information were requested by an insurer (or its designee utilization review organization), the prior authorization request would be considered to have been granted if the insurer (or its designee utilization review organization) fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within 72 hours after the date and time of the submission of additional information.

A prior authorization request granted under the bill would be valid for at least 60 calendar days unless a longer duration was clinically appropriate.

Reporting requirements

By June 1, 2022, and each following June 1, an insurer would have to report to DIFS the following aggregated trend data related to the insurer's prior authorization practices and experience for the prior plan year:

- The number of prior authorization requests.
- The number of prior authorization requests denied.
- The number of appeals received.
- The number of adverse determinations reversed on appeal.
- The number of the total number of prior authorization requests that were not submitted electronically.
- The top 10 services that were denied.
- The top 10 reasons prior authorization requests were denied.

By October 1, 2022, and each following October 1, DIFS would have to aggregate and deidentify the data collected above into a standard report that does not identify the name of the insurer that submitted the data. The report would have to be written in easily understandable language and posted on the department's public internet website.

Any data, documents, materials, or other information described above that has not been aggregated, deidentified, and otherwise compiled into the standard report posted by DIFS would be considered proprietary and to contain trade secrets and would be confidential and privileged and not subject to disclosure under the Freedom of Information Act.

MCL 500.2212c and proposed MCL 500.2212e

**FISCAL IMPACT:**

Senate Bill 247 would have an indeterminate fiscal impact on the Department of Insurance and Financial Services. The department would incur additional oversight and reporting burdens under the bill, but costs related to these activities may be sufficiently absorbed by existing departmental resources.

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■ 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.