HOUSE BILL NO. 5168

June 29, 2021, Introduced by Rep. Wozniak and referred to the Committee on Insurance.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

(MCL 500.100 to 500.8302) by adding section 3157c.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3157c. (1) If, before paying or providing reimbursement for a charge described in section 3157, an insurer requires a prior authorization for any treatment, product, service, accommodation, or rehabilitative occupational training, the insurer or its designee utilization review organization, if it has one, shall, by

January 1, 2023, 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. After January 1, 2022, an insurer described in this subsection or its designee utilization review organization and the health professional shall perform a prior authorization using only a standard electronic prior authorization transaction process that allows the transmission of clinical information, unless the health professional is not able to use the standard electronic prior authorization transaction process because of a temporary technological or electrical failure. The current prior authorization requirements must be described in detail and written in easily understandable language. An insurer described in this subsection or its designee utilization review organization shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to insureds, injured persons, health care professionals, and health care providers. Content published by a third party and licensed for use by an insurer described in this subsection or its designee utilization review organization may be made available through the insurer or its designee utilization review organization's secure, password-protected website if the access requirements of the website do not unreasonably restrict access to the content. The prior authorization requirements must be based on peer-reviewed clinical review criteria. All of the following apply to clinical review criteria under this subsection:

(a) Unless the criteria are developed as described in subdivision (g), the clinical review criteria must be criteria

developed by either of the following:

(*i*) An entity to which both of the following apply:

(A) The entity works directly with clinicians, either within the organization or outside the organization, to develop the clinical review criteria.

(B) The entity does not receive direct payments based on the outcome of the clinical care decision.

(*ii*) A professional medical specialty society.

(b) The clinical review criteria must take into account the needs of atypical patient populations and diagnoses.

(c) The clinical review criteria must ensure quality of care and access to needed treatment and training.

(d) The clinical review criteria must be evidence-based criteria.

(e) The clinical review criteria must be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.

(f) The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(g) Before establishing, or substantially or materially 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. If criteria are developed for a treatment or training provided by a health professional not licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556, 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 treatment or training.

(2) An insurer described in subsection (1) shall make available on the insurer's public website in a readily accessible format a list of all benefits that are subject to a prior authorization.

(3) If an insurer described in subsection (1) implements a new prior authorization requirement or restriction, or amends an existing requirement or restriction, the insurer shall ensure that the new or amended requirement or restriction is posted on the insurer's public website before its implementation. An insurer shall notify contracted health care providers via the insurer's provider portal of the new or amended requirement or restriction not less than 60 days before the requirement or restriction is implemented.

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

(5) For an adverse determination regarding a request for prior authorization for a benefit other than a prescription drug, the adverse determination must be made by a licensed physician. For an adverse determination of a treatment or training provided by a health professional that is not a licensed physician, a licensed physician may consider input from a health professional who is in the same profession as the health professional providing the health care service. The licensed physician shall make the adverse determination under this subsection under the general direction of the insurer's medical director who oversees the utilization

management program. Medical directors under this subsection must be licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

(6) For an adverse determination regarding a request for prior authorization for a prescription drug, the adverse determination must be made by a licensed pharmacist or licensed physician. The licensed pharmacist or licensed physician shall make the adverse determination under this subsection under the general direction of the insurer's medical director who oversees the utilization management program. Medical directors under this subsection must be licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

(7) If an insurer described in subsection (1) denies a prior authorization, the insurer or its designee utilization review organization shall, on issuing a benefit denial, notify the health professional and the injured person of all of the following:

(a) The reasons for the denial and related evidence-based criteria.

(b) The right to appeal the adverse determination.

(c) Instructions on how to file the appeal.

(d) Additional documentation necessary to support the appeal.

(8) Subject to subsection (9), an appeal of the denial under subsection (7) must be reviewed by a health professional to whom all of the following apply:

(a) The health professional does not have a direct financial

stake in the outcome of the appeal.

(b) The health professional has not been involved in making the adverse determination.

(c) The health professional considers all known clinical aspects of the health care services under review, including, but not limited to, a review of all pertinent medical records provided to the insurer or designee utilization review organization by the injured person's health care provider and any relevant records provided to the insurer or designee utilization review organization by a health care facility.

(d) 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.

(9) An insurer or its designee utilization review organization shall not affirm the denial of an appeal under subsection (8) unless the appeal is 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 provides the treatment or training. However, if an insurer or its designee utilization review organization cannot identify a licensed physician who meets the requirements described in this subsection without exceeding the applicable time limits imposed under subsection (10), the insurer or its designee utilization review organization may use a licensed physician in a similar specialty as considered appropriate, as determined by the insurer or its designee utilization review organization.

(10) After December 31, 2022 and before January 1, 2024, a

prior authorization request under this section that has not been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails within 9 calendar days after the date and time of submission of the prior authorization request to grant the request, deny the request, or require additional information from the health care provider. After December 31, 2023, a prior authorization request under this section that has not been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails within 7 calendar days after the date and time of submission of the prior authorization request to grant the request, deny the request, or require additional information from the health care provider. After December 31, 2022 and before January 1, 2024, if additional information is requested by an insurer or its designee utilization review organization, the prior authorization request is considered to have been granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails within 9 calendar days after the date and time of the submission of additional information to grant the request, deny the request, or otherwise respond to the request of the health care provider. After December 31, 2023, if additional information is requested by an insurer or its designee utilization review organization, the prior authorization request is considered to have been granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails

within 7 calendar days after the date and time of the submission of additional information to grant the request, deny the request, or otherwise respond to the request of the health care provider.

(11) After January 1, 2022, a prior authorization request under this section that has been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails within 72 hours after the date and time of submission of the prior authorization request to grant the request, deny the request, or require additional information from the health care provider. If additional information is requested by an insurer or its designee utilization review organization, the prior authorization request is considered to have been granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails within 72 hours after the date and time of the submission of additional information to grant the request, deny the request, or otherwise respond to the request of the health care provider.

(12) A prior authorization request granted under this section is valid for not less than 60 calendar days or for a duration that is clinically appropriate, whichever is later.

(13) By June 1, 2022, and each June 1 after that date, an insurer shall report to the department the following aggregated trend data related to the insurer's prior authorization practices and experience for the prior plan year:

(a) The number of prior authorization requests.

(b) The number of prior authorization requests denied.

(c) The number of appeals received.

(d) The number of adverse determinations reversed on appeal.

(e) Of the total number of prior authorization requests, the number of prior authorization requests that were not submitted electronically.

(f) The top 10 services that were denied.

(g) The top 10 reasons prior authorization requests were denied.

(14) By October 1, 2022, and each October 1 after that date, the department shall aggregate and deidentify the data collected under subsection (13) into a standard report and shall not identify the name of the insurer that submitted the data. The report must be written in easily understandable language and posted on the department's public internet website.

(15) All of the following apply to any data, documents, materials, or other information described in subsection (13) that has not been aggregated, deidentified, and otherwise compiled into the standard report described in subsection (14):

(a) The data, documents, materials, or other information is considered proprietary and to contain trade secrets.

(b) The data, documents, materials, or other information is confidential and privileged and is not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(16) An insurer described in subsection (1) shall 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:

(a) The performance of health care providers with respect to adherence to nationally recognized evidence-based medical

guidelines, appropriateness, efficiency, and other quality criteria.

(b) Involvement of contracted health care providers with an insurer described in subsection (1) to participate in a financial risk-sharing payment plan, that includes downside risk.

(c) Health provider specialty, experience, or other factors.

(17) As used in this section:

(a) "Adverse determination" means that term as defined in section 2213.

(b) "Evidence-based criteria" means criteria developed using evidence-based standards.

(c) "Evidence-based standard" means that term as defined in section 3 of the patient's right to independent review act, 2000 PA 251, MCL 550.1903.

(d) "Health care provider" means any of the following:

(*i*) A health facility as that term is defined in section 2006.

(*ii*) A health professional.

(e) "Health professional" means an individual licensed, registered, or otherwise authorized to engage in a health profession under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, or under the laws of another state to engage in a health profession.

(f) "Licensed pharmacist" means either of the following:

(*i*) A pharmacist licensed to engage in the practice of pharmacy under part 177 of the public health code, 1978 PA 368, MCL 333.17701 to 333.17780.

(*ii*) A pharmacist licensed in another state.

(g) "Licensed physician" means any of the following:

(*i*) A physician licensed to engage in the practice of medicine

under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097.

(*ii*) A physician licensed to engage in the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

(*iii*) A physician licensed in another state.

(h) "Peer-reviewed" means the clinical review criteria that is approved by a committee comprised 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 that promotes appropriate, safe, and cost-effective drug use.

(i) "Prescription drug" means that term as defined in section 2212c.

(j) "Prior authorization" means a determination by an insurer or utilization review organization that a requested treatment or training has been reviewed and, based on the information provided, satisfies the insurer or utilization review organization requirements for medical necessity and appropriateness.

(k) "Standardized electronic prior authorization transaction process" means a standardized transmission process, identified by the director 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 must allow health care providers to supply clinical

information under the standardized electronic prior authorization process. Standard electronic prior authorization transaction process does not include a facsimile.

(*l*) "Urgent" means the injured person is suffering from a health condition that may seriously jeopardize the injured person's life, health, or ability to regain maximum function or could subject the injured person to severe adverse health consequences that cannot be adequately managed without the care or treatment that is the subject of the prior authorization.

(m) "Utilization review organization" means that term as defined in section 3 of the patient's right to independent review act, 2000 PA 251, MCL 550.1903.