

SUBSTITUTE FOR  
SENATE BILL NO. 247

A bill to amend 1956 PA 218, entitled  
"The insurance code of 1956,"  
by amending section 2212c (MCL 500.2212c), as added by 2013 PA 30,  
and by adding section 2212e.

**THE PEOPLE OF THE STATE OF MICHIGAN ENACT:**

1           Sec. 2212c. (1) ~~On or before~~ **By** January 1, 2015, the workgroup  
2 shall develop a standard prior authorization methodology for use by  
3 prescribers to request and receive prior authorization from an  
4 insurer ~~when a policy, certificate, or contract~~ **if a health benefit**  
5 **plan** requires prior authorization for prescription drug benefits.  
6 The workgroup shall include in the standard prior authorization  
7 methodology the ability for the prescriber to designate the prior  
8 authorization request for expedited review. In order to designate a

1 prior authorization request for expedited review, the prescriber  
 2 shall certify that applying the ~~15-day standard~~ **5 business day**  
 3 review period may seriously jeopardize the life or health of the  
 4 patient or the patient's ability to regain maximum function.

5 (2) A prescription drug prior authorization workgroup is  
 6 created. ~~Within 30 days after the effective date of this section,~~  
 7 ~~the~~**The** department of ~~community health~~ **and human services** and the  
 8 department ~~of insurance and financial services~~ shall work together  
 9 and appoint members to the workgroup. The workgroup must consist of  
 10 a member who represents the department of ~~community health~~ **and**  
 11 **human services**, a member who represents the department, ~~of~~  
 12 ~~insurance and financial services~~, and members who represent  
 13 insurers, prescribers, pharmacists, hospitals, and other  
 14 stakeholders as determined necessary by the department of ~~community~~  
 15 ~~health~~ **and human services** and the department. ~~of insurance and~~  
 16 ~~financial services~~. The workgroup shall appoint a chairperson from  
 17 among its members. The chairperson of the workgroup shall schedule  
 18 workgroup meetings. The department of ~~community health~~ **and human**  
 19 **services** and the department ~~of insurance and financial services~~  
 20 shall organize the initial meeting of the workgroup and shall  
 21 provide administrative support for the workgroup.

22 (3) In developing the standard prior authorization methodology  
 23 under subsection (1), the workgroup shall consider all of the  
 24 following:

25 (a) Existing and potential technologies that could be used to  
 26 transmit a standard prior authorization request.

27 (b) The national standards pertaining to electronic prior  
 28 authorization developed by the ~~national council for prescription~~  
 29 ~~drug programs~~.**National Council for Prescription Drug Programs.**

1 (c) Any prior authorization forms and methodologies used in  
2 pilot programs in this state.

3 (d) Any prior authorization forms and methodologies developed  
4 by the federal ~~centers for medicare and medicaid services.~~**Centers**  
5 **for Medicare and Medicaid Services.**

6 (4) Beginning ~~on the effective date of this section,~~**March 14,**  
7 **2014,** an insurer may specify in writing the materials and  
8 information necessary to constitute a properly completed standard  
9 prior authorization request ~~when a policy, certificate, or contract~~  
10 **if a health benefit plan** requires prior authorization for  
11 prescription drug benefits.

12 (5) If the workgroup develops a paper form as the standard  
13 prior authorization methodology under subsection (1), the paper  
14 form ~~shall~~**must** meet all of the following requirements:

15 (a) Consist of not more than 2 pages. However, an insurer may  
16 request and require additional information beyond the 2-page  
17 limitation of this subdivision, if that information is specified in  
18 writing by the insurer under subsection (4). As used in this  
19 subdivision, "additional information" includes, but is not limited  
20 to, any of the following:

21 (i) Patient clinical information including, but not limited to,  
22 diagnosis, chart notes, lab information, and genetic tests.

23 (ii) Information necessary for approval of the prior  
24 authorization request under plan criteria.

25 (iii) Drug specific information including, but not limited to,  
26 medication history, duration of therapy, and treatment use.

27 (b) Be electronically available.

28 (c) Be electronically transmissible, including, but not  
29 limited to, transmission by facsimile or similar device.

1 (6) Beginning July 1, 2016, if an insurer uses a prior  
2 authorization methodology that utilizes an internet webpage,  
3 internet webpage portal, or similar electronic, internet, and web-  
4 based system, the prior authorization methodology described in  
5 subsection (5) does not apply. ~~Subsections~~ **Subsection** (4) ~~, (8),~~  
6 ~~and (9) apply~~ **and section 2212e apply** to a prior authorization  
7 methodology that utilizes an internet webpage, internet webpage  
8 portal, or similar electronic, internet, and web-based system.

9 (7) Beginning July 1, 2016, except as otherwise provided in  
10 subsection (6), an insurer shall use the standard prior  
11 authorization methodology developed under subsection (1) ~~when a~~  
12 ~~policy, certificate, or contract~~ **if a health benefit plan** requires  
13 prior authorization for prescription drug benefits.

14 ~~(8) Beginning January 1, 2016, a prior authorization request~~  
15 ~~that has not been certified for expedited review by the prescriber~~  
16 ~~is considered to have been granted by the insurer if the insurer~~  
17 ~~fails to grant the request, deny the request, or require additional~~  
18 ~~information of the prescriber within 15 days after the date and~~  
19 ~~time of submission of a standard prior authorization request under~~  
20 ~~this section. If additional information is requested by an insurer,~~  
21 ~~a prior authorization request under this subsection is not~~  
22 ~~considered granted if the prescriber fails to submit the additional~~  
23 ~~information within 15 days after the date and time of the original~~  
24 ~~submission of a properly completed standard prior authorization~~  
25 ~~request under this section. If additional information is requested~~  
26 ~~by an insurer, a prior authorization request is considered to have~~  
27 ~~been granted by the insurer if the insurer fails to grant the~~  
28 ~~request, deny the request, or otherwise respond to the request of~~  
29 ~~the prescriber within 15 days after the date and time of submission~~

1 ~~of the additional information. If additional information is~~  
2 ~~requested by an insurer, a prior authorization request under this~~  
3 ~~subsection is considered void if the prescriber fails to submit the~~  
4 ~~additional information within 21 days after the date and time of~~  
5 ~~the original submission of a properly completed standard prior~~  
6 ~~authorization request under this section.~~

7 ~~(9) Beginning January 1, 2016, a prior authorization request~~  
8 ~~that has been certified for expedited review by the prescriber is~~  
9 ~~considered to have been granted by the insurer if the insurer fails~~  
10 ~~to grant the request, deny the request, or require additional~~  
11 ~~information of the prescriber within 72 hours after the date and~~  
12 ~~time of submission of a standard prior authorization request under~~  
13 ~~this section. If additional information is requested by an insurer,~~  
14 ~~a prior authorization request under this subsection is not~~  
15 ~~considered granted if the prescriber fails to submit the additional~~  
16 ~~information within 72 hours after the date and time of the original~~  
17 ~~submission of a properly completed standard prior authorization~~  
18 ~~request under this section. If additional information is requested~~  
19 ~~by an insurer, a prior authorization request is considered to have~~  
20 ~~been granted by the insurer if the insurer fails to grant the~~  
21 ~~request, deny the request, or otherwise respond to the request of~~  
22 ~~the prescriber within 72 hours after the date and time of~~  
23 ~~submission of the additional information. If additional information~~  
24 ~~is requested by an insurer, a prior authorization request under~~  
25 ~~this subsection is considered void if the prescriber fails to~~  
26 ~~submit the additional information within 5 days after the date and~~  
27 ~~time of the original submission of a properly completed standard~~  
28 ~~prior authorization request under this section.~~

29 ~~(8) (10) As used in this section:~~

1           **(a) "Health benefit plan" means that term as defined in**  
 2 **section 2212e.**

3           **(b) ~~(a)~~"Insurer" means any of the following:**

4           **(i) An insurer issuing ~~an expense-incurred hospital, medical,~~**  
 5 **~~or surgical policy or certificate.~~or administering a health benefit**  
 6 **plan.**

7           **(ii) A health maintenance organization.**

8           **(iii) A health care corporation operating pursuant to the**  
 9 **nonprofit health care corporation reform act, 1980 PA 350, MCL**  
 10 **550.1101 to 550.1704.**

11           **(iv) A third party administrator of prescription drug benefits.**

12           **(c) ~~(b)~~"Prescriber" means that term as defined in section**  
 13 **17708 of the public health code, 1978 PA 368, MCL 333.17708.**

14           **(d) ~~(e)~~"Prescription drug" means that term as defined in**  
 15 **section 17708 of the public health code, 1978 PA 368, MCL**  
 16 **333.17708.**

17           **(e) ~~(d)~~"Prescription drug benefit" means the right to have a**  
 18 **payment made by an insurer ~~pursuant to prescription drug~~ **for a****  
 19 **prescription drug listed on the applicable formulary in accordance**  
 20 **with coverage contained within a ~~policy, certificate, or contract~~**  
 21 **health benefit plan delivered, issued for delivery, or renewed in**  
 22 **this state.**

23           **(f) ~~(e)~~"Workgroup" means the prescription drug prior**  
 24 **authorization workgroup created under subsection (2).**

25           **Sec. 2212e. (1) For an insurer that delivers, issues for**  
 26 **delivery, renews, or administers a health benefit plan in this**  
 27 **state, if the health benefit plan requires a prior authorization**  
 28 **with respect to any benefit, the insurer or its designee**  
 29 **utilization review organization shall, by January 1, 2023, make**

1 available a standardized electronic prior authorization request  
2 transaction process utilizing an internet webpage, internet webpage  
3 portal, or similar electronic, internet, and web-based system.  
4 Beginning January 1, 2023, an insurer described in this subsection  
5 or its designee utilization review organization and the health  
6 professional shall perform a prior authorization utilizing only a  
7 standard electronic prior authorization transaction process, which  
8 allows the transmission of clinical information, unless the health  
9 professional is not able to use the standard electronic prior  
10 authorization transaction process because of a temporary  
11 technological or electrical failure. The current prior  
12 authorization requirements must be described in detail and written  
13 in easily understandable language. An insurer described in this  
14 subsection or its designee utilization review organization shall  
15 make any current prior authorization requirements and restrictions,  
16 including the written clinical review criteria, readily accessible  
17 and conspicuously posted on its website to insureds, enrollees,  
18 health care professionals, and health care providers. Content  
19 published by a third party and licensed for use by an insurer  
20 described in this subsection or its designee utilization review  
21 organization may be made available through the insurer or its  
22 designee utilization review organization's secure, password-  
23 protected website if the access requirements of the website do not  
24 unreasonably restrict access to the content. The prior  
25 authorization requirements must be based on peer-reviewed clinical  
26 review criteria. All of the following apply to clinical review  
27 criteria under this subsection:

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

1 developed by either of the following:

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

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

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

8 (ii) A professional medical specialty society.

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

11 (c) The clinical review criteria must ensure quality of care  
12 and access to needed health care services.

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

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

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

20 (g) For coverage other than prescription drug benefit  
21 coverage, before establishing, or substantially or materially  
22 altering, its own written clinical review criteria, an insurer or  
23 its designee utilization review organization must obtain input from  
24 actively practicing licensed physicians representing major areas of  
25 the specialty. For coverage of a prescription drug benefit, before  
26 establishing, or substantially or materially altering, its own  
27 clinical review criteria, an insurer or its designee utilization  
28 review organization must obtain input from actively practicing  
29 licensed pharmacists or actively practicing licensed physicians. If

1 criteria are developed for a health care service provided by a  
2 health professional not licensed to engage in the practice of  
3 medicine under part 170 of the public health code, 1978 PA 368, MCL  
4 333.17001 to 333.17097, or osteopathic medicine and surgery under  
5 part 175 of the public health code, 1978 PA 368, MCL 333.17501 to  
6 333.17556, an insurer or designee utilization review organization  
7 must also seek input from a health professional in the same  
8 profession as the health professional providing the health care  
9 service.

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

14 (3) If an insurer described in subsection (1) implements a new  
15 prior authorization requirement or restriction, or amends an  
16 existing requirement or restriction, with respect to any benefit  
17 under a health benefit plan, the insurer shall ensure that the new  
18 or amended requirement or restriction is posted on the insurer's  
19 public website before its implementation. For a benefit that does  
20 not involve coverage of a prescription drug, an insurer shall  
21 notify contracted health care providers via the insurer's provider  
22 portal of the new or amended requirement or restriction not less  
23 than 60 days before the requirement or restriction is implemented.  
24 For coverage of a prescription drug, an insurer shall make  
25 available on the insurer's public website or notify contracted  
26 health care providers via the insurer's provider portal of the new  
27 or amended requirement or restriction not less than 45 days before  
28 the requirement or restriction is implemented unless any of the  
29 following apply:

1 (a) The United States Food and Drug Administration has done  
2 any of the following:

3 (i) Issued a statement that calls into question the clinical  
4 safety of the drug.

5 (ii) Required the manufacturers to conduct postmarket safety  
6 studies and clinical trials after the approval of the drug.

7 (iii) Issued any drug safety-related labeling changes.

8 (iv) Required the manufacturers to implement special risk  
9 management programs.

10 (b) The drug receives a new United States Food and Drug  
11 Administration approval and has become available.

12 (c) The United States Food and Drug Administration has  
13 approved expanded use of the drug.

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

17 (5) For an adverse determination regarding a request for prior  
18 authorization for a benefit other than a prescription drug, the  
19 adverse determination must be made by a licensed physician. For an  
20 adverse determination of a health care service provided by a health  
21 professional that is not a licensed physician, a licensed physician  
22 may consider input from a health professional who is in the same  
23 profession as the health professional providing the health care  
24 service. The licensed physician shall make the adverse  
25 determination under this subsection under the general direction of  
26 the insurer's medical director who oversees the utilization  
27 management program. Medical directors under this subsection must be  
28 licensed to engage in the practice of medicine under part 170 of  
29 the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or

1 the practice of osteopathic medicine and surgery under part 175 of  
2 the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

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

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

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

20 (b) The right to appeal the adverse determination.

21 (c) Instructions on how to file the appeal.

22 (d) Additional documentation necessary to support the appeal.

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

26 (a) The health professional does not have a direct financial  
27 stake in the outcome of the appeal.

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

1           (c) The health professional considers all known clinical  
2 aspects of the health care services under review, including, but  
3 not limited to, a review of all pertinent medical records provided  
4 to the insurer or designee utilization review organization by the  
5 insured or enrollee's health care provider and any relevant records  
6 provided to the insurer or designee utilization review organization  
7 by a health care facility.

8           (d) The health professional may consider input from a health  
9 professional who is licensed in the same profession as the health  
10 professional providing the health care service or a licensed  
11 pharmacist if the adverse decision is regarding a prescription  
12 drug.

13           (9) An insurer or its designee utilization review organization  
14 shall not affirm the denial of an appeal under subsection (8)  
15 unless the appeal is reviewed by a licensed physician who is board  
16 certified or eligible in the same specialty as a health care  
17 provider who typically manages the medical condition or disease or  
18 provides the health care service. However, if an insurer or its  
19 designee utilization review organization cannot identify a licensed  
20 physician who meets the requirements described in this subsection  
21 without exceeding the applicable time limits imposed under  
22 subsection (10), the insurer or its designee utilization review  
23 organization may utilize a licensed physician in a similar  
24 specialty as considered appropriate, as determined by the insurer  
25 or its designee utilization review organization.

26           (10) Beginning January 1, 2023 through December 31, 2023, a  
27 prior authorization request under this section that has not been  
28 certified as urgent by the health care provider is considered  
29 granted by the insurer or its designee utilization review

1 organization if the insurer or its designee utilization review  
2 organization fails to grant the request, deny the request, or  
3 require additional information of the health care provider within 9  
4 calendar days after the date and time of submission of the prior  
5 authorization. After December 31, 2023, a prior authorization  
6 request under this section that has not been certified as urgent by  
7 the health care provider is considered granted by the insurer or  
8 its designee utilization review organization if the insurer or its  
9 designee utilization review organization fails to grant the  
10 request, deny the request, or require additional information of the  
11 health care provider within 7 calendar days after the date and time  
12 of submission of the prior authorization. Beginning January 1, 2023  
13 through December 31, 2023, if additional information is requested  
14 by an insurer or its designee utilization review organization, the  
15 prior authorization request is considered to have been granted by  
16 the insurer or its designee utilization review organization if the  
17 insurer or its designee utilization review organization fails to  
18 grant the request, deny the request, or otherwise respond to the  
19 request of the health care provider within 9 calendar days after  
20 the date and time of the submission of additional information.  
21 After December 31, 2023, if additional information is requested by  
22 an insurer or its designee utilization review organization, the  
23 prior authorization request is considered to have been granted by  
24 the insurer or its designee utilization review organization if the  
25 insurer or its designee utilization review organization fails to  
26 grant the request, deny the request, or otherwise respond to the  
27 request of the health care provider within 7 calendar days after  
28 the date and time of the submission of additional information.

29 (11) Beginning January 1, 2023, a prior authorization request

1 under this section that has been certified as urgent by the health  
2 care provider is considered granted by the insurer or its designee  
3 utilization review organization if the insurer or its designee  
4 utilization review organization fails to grant the request, deny  
5 the request, or require additional information of the health care  
6 provider within 72 hours after the date and time of submission of  
7 the prior authorization request. If additional information is  
8 requested by an insurer or its designee utilization review  
9 organization, the prior authorization request is considered to have  
10 been granted by the insurer or its designee utilization review  
11 organization if the insurer or its designee utilization review  
12 organization fails to grant the request, deny the request, or  
13 otherwise respond to the request of the health care provider within  
14 72 hours after the date and time of the submission of additional  
15 information.

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

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

- 23 (a) The number of prior authorization requests.  
24 (b) The number of prior authorization requests denied.  
25 (c) The number of appeals received.  
26 (d) The number of adverse determinations reversed on appeal.  
27 (e) Of the total number of prior authorization requests, the  
28 number of prior authorization requests that were not submitted  
29 electronically.

1 (f) The top 10 services that were denied.

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

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

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

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

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

19 (16) An insurer described in subsection (1) shall adopt a  
20 program, developed in consultation with health care providers  
21 participating with the insurer, that promotes the modification of  
22 prior authorization requirements of certain prescription drugs,  
23 medical care, or related benefits, based on any of the following:

24 (a) The performance of health care providers with respect to  
25 adherence to nationally recognized evidence-based medical  
26 guidelines, appropriateness, efficiency, and other quality  
27 criteria.

28 (b) Involvement of contracted health care providers with an  
29 insurer described in subsection (1) to participate in a financial

1 risk-sharing payment plan, that includes downside risk.

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

3 (17) As used in this section:

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

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

8 (c) "Evidence-based standard" means that term as defined in  
9 section 3 of the patient's right to independent review act, 2000 PA  
10 251, MCL 550.1903.

11 (d) "Health benefit plan" means an individual or group health  
12 insurance policy, an individual or group health maintenance  
13 organization contract, or a self-funded plan established or  
14 maintained by this state or a local unit of government for its  
15 employees. Health benefit plan includes prescription drug benefits.

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

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

18 (ii) A health professional.

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

24 (g) "Insurer" means that term as defined in section 2212c.

25 (h) "Licensed pharmacist" means either of the following:

26 (i) A pharmacist licensed to engage in the practice of pharmacy  
27 under part 177 of the public health code, 1978 PA 368, MCL  
28 333.17701 to 333.17780.

29 (ii) A pharmacist licensed in another state.

1 (i) "Licensed physician" means any of the following:

2 (i) A physician licensed to engage in the practice of medicine  
3 under part 170 of the public health code, 1978 PA 368, MCL  
4 333.17001 to 333.17097.

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

8 (iii) A physician licensed in another state.

9 (j) "Peer-reviewed" means the clinical review criteria that is  
10 approved by a committee comprised of clinicians, including licensed  
11 physicians or licensed pharmacists, or both, that meets at  
12 regularly-scheduled intervals and evaluates, among other things,  
13 pharmaceutical literature or medical literature, or both, and  
14 scientific evidence to develop criteria that promotes appropriate,  
15 safe, and cost-effective drug utilization.

16 (k) "Prescription drug" means that term as defined in section  
17 2212c.

18 (l) "Prescription drug benefit" means that term as defined in  
19 section 2212c.

20 (m) "Prior authorization" means a determination by an insurer  
21 or utilization review organization that a requested health care  
22 benefit has been reviewed and, based on the information provided,  
23 satisfies the insurer or utilization review organization  
24 requirements for medical necessity and appropriateness.

25 (n) "Standardized electronic prior authorization transaction  
26 process" means a standardized transmission process, identified by  
27 the director and aligned with standards that are nationally  
28 accepted, to enable prior authorization requests to be accessible,  
29 submitted by health care providers, and accepted by insurers or

1 their designee utilization review organizations electronically  
2 through secure electronic transmissions with the goal of maximizing  
3 administrative simplification, efficiency, and timeliness. The  
4 process must allow health care providers to supply clinical  
5 information under the standardized electronic prior authorization  
6 process. Standard electronic prior authorization transaction  
7 process does not include a facsimile.

8 (o) "Urgent" means an insured or enrollee is suffering from a  
9 health condition that may seriously jeopardize the insured's life,  
10 health, or ability to regain maximum function or could subject the  
11 insured or enrollee to severe adverse health consequences that  
12 cannot be adequately managed without the care or treatment that is  
13 the subject of the prior authorization.

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