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BILL



ANALYSIS

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Senate Bill 178 (Substitute S-1 as passed by the Senate)  
Senate Bill 179 (as passed by the Senate)  
Sponsor: Senator Tonya Schuitmaker  
Committee: Insurance

Date Completed: 3-27-13

### **RATIONALE**

In an effort to contain costs, some health insurance companies require prior authorization before they will cover certain prescription drugs, such as a brand name drug for which a generic version is available, or a drug that is particularly expensive. Generally, the prior authorization process requires a prescriber, such as a physician, to fill out a separate form documenting that the specific drug is medically necessary and submit the request to the insurer. The process evidently can be time-consuming and burdensome for health care providers, partly because each insurer uses a different form for prior authorization requests, and some of the forms are quite long. It has been suggested that a standardized form should be developed for use by all medical insurers doing business in Michigan, and that time frames for processing prior authorization requests should be established.

### **CONTENT**

**Senate Bill 178 (S-1) would add Section 2212c to the Insurance Code to do the following:**

- **Create a workgroup and require it to develop, by January 1, 2015, a standard methodology that a prescriber would have to use to request and receive prior authorization for prescription drug benefits, when required by an insurer.**
- **Require the methodology to enable a prescriber to designate a prior authorization request for expedited review.**

- **Require an insurer to use the standard methodology beginning July 1, 2016.**
- **Provide that a prior authorization request that was not certified for expedited review would be considered granted if the insurer failed to grant or deny it or require additional information within 15 days, beginning January 1, 2016.**
- **Provide that an expedited request would be considered granted if the insurer failed to grant or deny it or require additional information within 72 hours, beginning January 1, 2016.**

**Senate Bill 179 would amend the Nonprofit Health Care Corporation Reform Act to provide that Section 2212c of the Insurance Code would apply to Blue Cross Blue Shield of Michigan (BCBSM).**

Senate Bill 179 is tie-barred to Senate Bill 178, which is described below in further detail.

The bill would create a prescription drug prior authorization workgroup. Within 30 days after the bill took effect, the Department of Community Health (DCH) and the Department of Insurance and Financial Services (DIFS) would have to work together to appoint workgroup members. The workgroup would have to consist of one member representing each Department, as well as members representing insurers, prescribers, pharmacists, hospitals, and other stakeholders determined necessary by the DCH and DIFS. The workgroup would

have to appoint a chairperson from among its members. The chairperson would have to schedule workgroup meetings. The DCH and DIFS would have to organize the initial meeting and provide administrative support for the workgroup.

By January 1, 2015, the workgroup would have to 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 required prior authorization for prescription drug benefits.

("Insurer" would mean an insurer issuing an expense-incurred hospital, medical, or surgical policy or certificate; a health maintenance organization; BCBSM; or a third-party administrator of prescription drug benefits.

"Prescriber" would mean that term as defined in the Public Health Code, i.e., a licensed dentist, physician, optometrist, veterinarian, or other licensed health professional acting under the delegation of a licensed doctor of medicine or osteopathic medicine and surgery.

"Prescription drug benefit" would mean 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 Michigan.)

The workgroup would have to include in the methodology the ability for the prescriber to designate the request for expedited review. In order to designate a request for expedited review, the prescriber would have to certify that applying the 15-day standard review period would seriously jeopardize the patient's life, health, or ability to regain maximum function.

In developing the standard methodology, the workgroup would have to consider all of the following:

- Existing and potential technologies that could be used to transmit a standard prior authorization request.
- The national standards pertaining to electronic prior authorization developed by the National Council for Prescription Drug Programs.

- Any prior authorization forms and methodologies used in pilot programs in Michigan.
- Any prior authorization forms and methodologies developed by the Federal Centers for Medicare and Medicaid Services.

Beginning on the bill's effective date, an insurer could specify in writing the materials and information necessary to constitute a properly completed standard prior authorization request when a policy, certificate, or contract required prior authorization for prescription drug benefits.

If the workgroup developed a paper form as the standard methodology, the form would have to be electronically available and electronically transmissible, including by facsimile or similar device. The paper form could not consist of more than two pages. An insurer could request and require additional information beyond the two-page limitation, however, if the insurer specified that information in writing. "Additional information" would include the following:

- Patient clinical information, including diagnosis, chart notes, lab information, and genetic tests.
- Information necessary for approval of the prior authorization request under plan criteria.
- Drug-specific information, including medication history, duration of therapy, and treatment use.

Beginning July 1, 2016, if an insurer used a prior authorization methodology that used an internet webpage or webpage portal, or similar electronic, internet, and web-based system, the standard paper form would not apply. Such a methodology would be subject to the bill's provision allowing an insurer to specify in writing the materials and information necessary for a properly completed prior authorization request, as well as provisions regarding the timeline for responding to a request (described below).

Beginning July 1, 2016, except as provided for an electronic, internet, or web-based system, an insurer would have to use the standard prior authorization methodology developed under the bill when a policy, certificate, or contract required it.

Beginning January 1, 2016, a prior authorization request that the prescriber had not certified for expedited review would be considered granted if the insurer failed to grant or deny the request or require additional information within 15 days after the date and time the request was submitted. If the insurer required additional information, a request would not be considered granted if the prescriber failed to submit the information within 15 days after the date and time of the original submission of a properly completed request. A request would be considered granted if the insurer failed to grant or deny it, or otherwise respond, within 15 days after the prescriber submitted the additional information. A request would be considered void if the prescriber failed to submit the additional information within 21 days after the original request submission.

Beginning January 1, 2016, a prior authorization request that the prescriber certified for expedited review would be considered granted if the insurer failed to grant or deny it, or require additional information of the prescriber, within 72 hours after the request was submitted. If the insurer required additional information, a request would not be considered granted if the prescriber failed to submit the information within 72 hours after the properly completed request was submitted. A request would be considered granted if the insurer failed to grant, deny, or otherwise respond within 72 hours after the additional information was submitted. The request would be considered void if the prescriber failed to submit the additional information within five days after submission of the original properly completed request.

Proposed MCL 500.2212c (S.B. 178)  
Proposed MCL 550.1402d (S.B. 179)

## **ARGUMENTS**

*(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)*

### **Supporting Argument**

Currently, there are more than 150 health insurance providers in Michigan, each with its own form for prior authorization requests. While insurers call for much of the same information, some require more than others and have lengthy forms. Furthermore,

insurance companies have different methods for submission--some allow prior authorization requests to be submitted electronically, while others require paper forms. The various formats require physicians and their staff to spend a significant amount of time sorting through thousands of pages of paperwork, consisting of largely redundant information.

In recent years, there has been a movement to improve health care delivery through technology modernization and other efficiencies, such as the use of electronic health records. The bills would further these efforts by requiring a standard methodology to be used for prior authorization requests, addressing electronic request submissions, and limiting the paper form to two pages. Together with the prescribed time frames for responding to the requests, these provisions would allow insurers to continue using cost containment measures while reducing delays in access to medication, enabling providers to dedicate more time to interacting with patients, and improving patient outcomes.

**Response:** Streamlining the prior authorization process is a worthwhile endeavor; it is possible, however, that a standardized form might not accommodate all of the information necessary in certain situations. This could require multiple contacts between a prescriber and an insurer, and result in the delay or denial of authorization. Also, in developing the standardized methodology, the workgroup should take into account that any prior authorization form must meet certain Federal requirements and be approved by the Centers for Medicare and Medicaid Services in order to be used by Medicaid or Medicare plans.

Legislative Analyst: Julie Cassidy

## **FISCAL IMPACT**

A standard prior authorization form could reduce administrative costs for insurers. This could lead to marginally lower costs for insurance, which would result in a small, indeterminate reduction in employee benefit costs for State and local government.

The bills also would have a minor, but negative direct fiscal impact on the Department of Insurance and Financial Services and the Department of Community Health. The required workgroup would likely

be supported by existing DIFS and DCH resources.

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.