

SUBSTITUTE FOR
SENATE BILL NO. 178

(As amended March 20, 2013)

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
(MCL 500.100 to 500.8302) by adding section 2212c.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 SEC. 2212C. (1) ON OR BEFORE 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 REQUIRES PRIOR
5 AUTHORIZATION FOR PRESCRIPTION DRUG BENEFITS. THE <<WORKGROUP>>
6 SHALL INCLUDE IN THE STANDARD PRIOR AUTHORIZATION METHODOLOGY THE
7 ABILITY FOR THE PRESCRIBER TO DESIGNATE THE PRIOR AUTHORIZATION
8 REQUEST FOR EXPEDITED REVIEW. IN ORDER TO DESIGNATE A PRIOR
9 AUTHORIZATION REQUEST FOR EXPEDITED REVIEW, THE PRESCRIBER SHALL
10 CERTIFY THAT APPLYING THE 15-DAY STANDARD REVIEW PERIOD MAY

Senate Bill No. 178 as amended March 20, 2013

1 SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE PATIENT OR THE
2 PATIENT'S ABILITY TO REGAIN MAXIMUM FUNCTION.

3 (2) A PRESCRIPTION DRUG PRIOR AUTHORIZATION WORKGROUP IS
4 CREATED. WITHIN 30 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION,
5 THE DEPARTMENT OF COMMUNITY HEALTH AND THE DEPARTMENT OF INSURANCE
6 AND FINANCIAL SERVICES SHALL WORK TOGETHER AND APPOINT MEMBERS TO
7 THE WORKGROUP. THE WORKGROUP MUST CONSIST OF A MEMBER WHO REPRESENTS
8 THE DEPARTMENT OF COMMUNITY HEALTH, A MEMBER WHO REPRESENTS THE
9 DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES, AND MEMBERS WHO
REPRESENT INSURERS, PRESCRIBERS, PHARMACISTS, HOSPITALS, AND OTHER
STAKEHOLDERS AS DETERMINED NECESSARY BY THE DEPARTMENT OF COMMUNITY
HEALTH AND THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES. THE
WORKGROUP SHALL APPOINT A CHAIRPERSON FROM AMONG ITS MEMBERS. THE
CHAIRPERSON OF THE WORKGROUP SHALL SCHEDULE WORKGROUP MEETINGS. THE
DEPARTMENT OF COMMUNITY HEALTH AND THE DEPARTMENT OF INSURANCE AND
FINANCIAL SERVICES SHALL ORGANIZE THE INITIAL MEETING OF THE WORKGROUP
AND SHALL PROVIDE ADMINISTRATIVE SUPPORT FOR THE WORKGROUP.

10 (3) <<

11
12 >> IN DEVELOPING THE

13 STANDARD PRIOR AUTHORIZATION METHODOLOGY UNDER SUBSECTION (1), THE

14 << >> WORKGROUP SHALL CONSIDER ALL OF THE FOLLOWING:

15 (A) EXISTING AND POTENTIAL TECHNOLOGIES THAT COULD BE USED TO
16 TRANSMIT A STANDARD PRIOR AUTHORIZATION REQUEST.

17 (B) THE NATIONAL STANDARDS PERTAINING TO ELECTRONIC PRIOR
18 AUTHORIZATION DEVELOPED BY THE NATIONAL COUNCIL FOR PRESCRIPTION
19 DRUG PROGRAMS.

20 (C) ANY PRIOR AUTHORIZATION FORMS AND METHODOLOGIES USED IN
21 PILOT PROGRAMS IN THIS STATE.

22 (D) ANY PRIOR AUTHORIZATION FORMS AND METHODOLOGIES DEVELOPED
23 BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES.

24 (4) BEGINNING ON THE EFFECTIVE DATE OF THIS SECTION, AN
25 INSURER MAY SPECIFY IN WRITING THE MATERIALS AND INFORMATION
26 NECESSARY TO CONSTITUTE A PROPERLY COMPLETED STANDARD PRIOR
27 AUTHORIZATION REQUEST WHEN A POLICY, CERTIFICATE, OR CONTRACT

Senate Bill No. 178 as amended March 20, 2013

1 REQUIRES PRIOR AUTHORIZATION FOR PRESCRIPTION DRUG BENEFITS.

2 (5) IF THE <<WORKGROUP>> DEVELOPS A PAPER FORM AS THE STANDARD
3 PRIOR AUTHORIZATION METHODOLOGY UNDER SUBSECTION (1), THE PAPER
4 FORM SHALL MEET ALL OF THE FOLLOWING REQUIREMENTS:

5 (A) CONSIST OF NOT MORE THAN 2 PAGES. HOWEVER, AN INSURER MAY
6 REQUEST AND REQUIRE ADDITIONAL INFORMATION BEYOND THE 2-PAGE
7 LIMITATION OF THIS SUBDIVISION, IF THAT INFORMATION IS SPECIFIED IN
8 WRITING BY THE INSURER UNDER SUBSECTION (4). AS USED IN THIS
9 SUBDIVISION, "ADDITIONAL INFORMATION" INCLUDES, BUT IS NOT LIMITED
10 TO, ANY OF THE FOLLOWING:

11 (i) PATIENT CLINICAL INFORMATION INCLUDING, BUT NOT LIMITED TO,
12 DIAGNOSIS, CHART NOTES, LAB INFORMATION, AND GENETIC TESTS.

13 (ii) INFORMATION NECESSARY FOR APPROVAL OF THE PRIOR
14 AUTHORIZATION REQUEST UNDER PLAN CRITERIA.

15 (iii) DRUG SPECIFIC INFORMATION INCLUDING, BUT NOT LIMITED TO,
16 MEDICATION HISTORY, DURATION OF THERAPY, AND TREATMENT USE.

17 (B) BE ELECTRONICALLY AVAILABLE.

18 (C) BE ELECTRONICALLY TRANSMISSIBLE, INCLUDING, BUT NOT
19 LIMITED TO, TRANSMISSION BY FACSIMILE OR SIMILAR DEVICE.

20 (6) BEGINNING JULY 1, <<2016>>, IF AN INSURER USES A PRIOR
21 AUTHORIZATION METHODOLOGY THAT UTILIZES AN INTERNET WEBPAGE,
22 INTERNET WEBPAGE PORTAL, OR SIMILAR ELECTRONIC, INTERNET, AND WEB-
23 BASED SYSTEM, THE PRIOR AUTHORIZATION METHODOLOGY DESCRIBED IN
24 SUBSECTION (5) DOES NOT APPLY. SUBSECTIONS (4), (8), AND (9) APPLY
25 TO A PRIOR AUTHORIZATION METHODOLOGY THAT UTILIZES AN INTERNET
26 WEBPAGE, INTERNET WEBPAGE PORTAL, OR SIMILAR ELECTRONIC, INTERNET,
27 AND WEB-BASED SYSTEM.

Senate Bill No. 178 as amended March 20, 2013

1 (7) BEGINNING JULY 1, <<2016>>, EXCEPT AS OTHERWISE PROVIDED IN
2 SUBSECTION (6), AN INSURER SHALL USE THE STANDARD PRIOR
3 AUTHORIZATION METHODOLOGY DEVELOPED UNDER SUBSECTION (1) WHEN A
4 POLICY, CERTIFICATE, OR CONTRACT REQUIRES PRIOR AUTHORIZATION FOR
5 PRESCRIPTION DRUG BENEFITS.

6 (8) BEGINNING JANUARY 1, <<2016>>, A PRIOR AUTHORIZATION REQUEST
7 THAT HAS NOT BEEN CERTIFIED FOR EXPEDITED REVIEW BY THE PRESCRIBER
8 IS CONSIDERED TO HAVE BEEN GRANTED BY THE INSURER IF THE INSURER
9 FAILS TO GRANT THE REQUEST, DENY THE REQUEST, OR REQUIRE ADDITIONAL
10 INFORMATION OF THE PRESCRIBER WITHIN 15 DAYS AFTER THE DATE AND
11 TIME OF SUBMISSION OF A STANDARD PRIOR AUTHORIZATION REQUEST UNDER
12 THIS SECTION. IF ADDITIONAL INFORMATION IS REQUESTED BY AN INSURER,
13 A PRIOR AUTHORIZATION REQUEST UNDER THIS SUBSECTION IS NOT
14 CONSIDERED GRANTED IF THE PRESCRIBER FAILS TO SUBMIT THE ADDITIONAL
15 INFORMATION WITHIN 15 DAYS AFTER THE DATE AND TIME OF THE ORIGINAL
16 SUBMISSION OF A PROPERLY COMPLETED STANDARD PRIOR AUTHORIZATION
17 REQUEST UNDER THIS SECTION. IF ADDITIONAL INFORMATION IS REQUESTED
18 BY AN INSURER, A PRIOR AUTHORIZATION REQUEST IS CONSIDERED TO HAVE
19 BEEN GRANTED BY THE INSURER IF THE INSURER FAILS TO GRANT THE
20 REQUEST, DENY THE REQUEST, OR OTHERWISE RESPOND TO THE REQUEST OF
21 THE PRESCRIBER WITHIN 15 DAYS AFTER THE DATE AND TIME OF SUBMISSION
22 OF THE ADDITIONAL INFORMATION. IF ADDITIONAL INFORMATION IS
23 REQUESTED BY AN INSURER, A PRIOR AUTHORIZATION REQUEST UNDER THIS
24 SUBSECTION IS CONSIDERED VOID IF THE PRESCRIBER FAILS TO SUBMIT THE
25 ADDITIONAL INFORMATION WITHIN 21 DAYS AFTER THE DATE AND TIME OF
26 THE ORIGINAL SUBMISSION OF A PROPERLY COMPLETED STANDARD PRIOR
27 AUTHORIZATION REQUEST UNDER THIS SECTION.

Senate Bill No. 178 as amended March 20, 2013

1 (9) BEGINNING JANUARY 1, <<2016>>, A PRIOR AUTHORIZATION REQUEST
2 THAT HAS BEEN CERTIFIED FOR EXPEDITED REVIEW BY THE PRESCRIBER IS
3 CONSIDERED TO HAVE BEEN GRANTED BY THE INSURER IF THE INSURER FAILS
4 TO GRANT THE REQUEST, DENY THE REQUEST, OR REQUIRE ADDITIONAL
5 INFORMATION OF THE PRESCRIBER WITHIN 72 HOURS AFTER THE DATE AND
6 TIME OF SUBMISSION OF A STANDARD PRIOR AUTHORIZATION REQUEST UNDER
7 THIS SECTION. IF ADDITIONAL INFORMATION IS REQUESTED BY AN INSURER,
8 A PRIOR AUTHORIZATION REQUEST UNDER THIS SUBSECTION IS NOT
9 CONSIDERED GRANTED IF THE PRESCRIBER FAILS TO SUBMIT THE ADDITIONAL
10 INFORMATION WITHIN 72 HOURS AFTER THE DATE AND TIME OF THE ORIGINAL
11 SUBMISSION OF A PROPERLY COMPLETED STANDARD PRIOR AUTHORIZATION
12 REQUEST UNDER THIS SECTION. IF ADDITIONAL INFORMATION IS REQUESTED
13 BY AN INSURER, A PRIOR AUTHORIZATION REQUEST IS CONSIDERED TO HAVE
14 BEEN GRANTED BY THE INSURER IF THE INSURER FAILS TO GRANT THE
15 REQUEST, DENY THE REQUEST, OR OTHERWISE RESPOND TO THE REQUEST OF
16 THE PRESCRIBER WITHIN 72 HOURS AFTER THE DATE AND TIME OF
17 SUBMISSION OF THE ADDITIONAL INFORMATION. IF ADDITIONAL INFORMATION
18 IS REQUESTED BY AN INSURER, A PRIOR AUTHORIZATION REQUEST UNDER
19 THIS SUBSECTION IS CONSIDERED VOID IF THE PRESCRIBER FAILS TO
20 SUBMIT THE ADDITIONAL INFORMATION WITHIN 5 DAYS AFTER THE DATE AND
21 TIME OF THE ORIGINAL SUBMISSION OF A PROPERLY COMPLETED STANDARD
22 PRIOR AUTHORIZATION REQUEST UNDER THIS SECTION.

23 (10) AS USED IN THIS SECTION:

24 (A) "INSURER" MEANS ANY OF THE FOLLOWING:

25 (i) AN INSURER ISSUING AN EXPENSE-INCURRED HOSPITAL, MEDICAL,
26 OR SURGICAL POLICY OR CERTIFICATE.

27 (ii) A HEALTH MAINTENANCE ORGANIZATION.

Senate Bill No. 178 as amended March 20, 2013

1 (iii) A HEALTH CARE CORPORATION OPERATING PURSUANT TO THE
2 NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL
3 550.1101 TO 550.1704.

4 (iv) A THIRD PARTY ADMINISTRATOR OF PRESCRIPTION DRUG BENEFITS.

5 (B) "PRESCRIBER" MEANS THAT TERM AS DEFINED IN SECTION 17708
6 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.17708.

7 (C) "PRESCRIPTION DRUG" MEANS THAT TERM AS DEFINED IN SECTION
8 17708 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.17708.

9 (D) "PRESCRIPTION DRUG BENEFIT" MEANS THE RIGHT TO HAVE A
10 PAYMENT MADE BY AN INSURER PURSUANT TO PRESCRIPTION DRUG COVERAGE
11 CONTAINED WITHIN A POLICY, CERTIFICATE, OR CONTRACT DELIVERED,
12 ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE.

<<(E) "WORKGROUP" MEANS THE PRESCRIPTION DRUG PRIOR AUTHORIZATION
WORKGROUP CREATED UNDER SUBSECTION (2).>>