

SUBSTITUTE FOR  
SENATE BILL NO. 612

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 listed on the applicable formulary in accordance with**  
 20 **coverage contained within a ~~policy, certificate, or contract~~ health**  
 21 **benefit plan delivered, issued for delivery, or renewed in this**  
 22 **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, 2022, 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, 2022, 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 includes the transmission of clinical information, unless the  
9 health professional is not able to use the standard electronic  
10 prior 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. The prior authorization  
14 requirements must be based on peer-reviewed clinical review  
15 criteria. All of the following apply to clinical review criteria  
16 under this subsection:

17 (a) Unless the criteria are developed as described in  
18 subdivision (h), the clinical review criteria must be criteria  
19 developed by either of the following:

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

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

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

26 (ii) A professional medical specialty society.

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

29 (c) The clinical review criteria must ensure quality of care

1 and access to needed health care services.

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

4 (e) The clinical review criteria must be publicly available  
5 free of charge.

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

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

11 (h) For coverage other than prescription drug benefit  
12 coverage, before establishing, or substantially or materially  
13 altering, its own written clinical review criteria, an insurer or  
14 its designee utilization review organization must obtain input from  
15 actively practicing licensed physicians representing major areas of  
16 the specialty. For coverage of a prescription drug benefit, before  
17 establishing, or substantially or materially altering, its own  
18 clinical review criteria, an insurer or its designee review  
19 organization must obtain input from actively practicing licensed  
20 pharmacists. If criteria are developed for a health care service  
21 provided by a health professional not licensed to engage in the  
22 practice of medicine under part 170 of the public health code, 1978  
23 PA 368, MCL 333.17001 to 333.17097, or osteopathic medicine and  
24 surgery under part 175 of the public health code, 1978 PA 368, MCL  
25 333.17501 to 333.17556, an insurer or designee utilization review  
26 organization must also seek input from a health professional in the  
27 same profession as the health professional providing the health  
28 care service.

29 (2) An insurer described in subsection (1) shall make



1 available on the insurer's public website in a readily accessible  
2 format a list of all benefits that are subject to a prior  
3 authorization under the health benefit plan.

4 (3) Except as otherwise provided in subsection (4), an insurer  
5 described in subsection (1) or its designee utilization review  
6 organization shall ensure that an adverse determination, other than  
7 an adverse determination of prescription drug coverage, is made by  
8 a licensed physician. For an adverse determination of a health care  
9 service provided by a health professional that is not a licensed  
10 physician, the licensed physician may consider input from a health  
11 professional who is in the same profession as the health  
12 professional providing the health care service. The licensed  
13 physician shall make the adverse determination under the clinical  
14 direction of 1 of the insurer's medical directors who is  
15 responsible for the provision of health care items and services  
16 provided to insureds or enrollees. Medical directors under this  
17 subsection must be licensed to engage in the practice of medicine  
18 under part 170 of the public health code, 1978 PA 368, MCL  
19 333.17001 to 333.17097, or the practice of osteopathic medicine and  
20 surgery under part 175 of the public health code, 1978 PA 368, MCL  
21 333.17501 to 333.17556.

22 (4) An insurer described in subsection (1) or its designee  
23 utilization review organization shall ensure that an adverse  
24 determination of a prescription drug benefit is made by a licensed  
25 pharmacist under the clinical direction of 1 of the insurer's  
26 medical directors who is responsible for the provision of health  
27 care items and services provided to insureds or enrollees. Medical  
28 directors under this subsection must be licensed to engage in the  
29 practice of medicine under part 170 of the public health code, 1978

1 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic  
2 medicine and surgery under part 175 of the public health code, 1978  
3 PA 368, MCL 333.17501 to 333.17556.

4 (5) If an insurer described in subsection (1) implements a new  
5 prior authorization requirement or restriction, or amends an  
6 existing requirement or restriction, the insurer shall ensure that  
7 the new or amended requirement or restriction is posted on the  
8 insurer's public website before its implementation. For a medical  
9 benefit that is not a prescription drug benefit, an insurer shall  
10 notify contracted health care providers via the insurer's provider  
11 portal of the new or amended requirement or restriction not less  
12 than 60 days before the requirement or restriction is implemented.  
13 For a prescription drug benefit, an insurer shall notify contracted  
14 health care providers via the insurer's provider portal of the new  
15 or amended requirement or restriction not less than 30 days before  
16 the requirement or restriction is implemented.

17 (6) If an insurer described in subsection (1) denies a prior  
18 authorization, the insurer or its designee utilization review  
19 organization shall, on issuing a medical benefit denial, notify the  
20 health professional and insured or enrollee of the reasons for the  
21 denial and related evidence-based criteria. Subject to subsection  
22 (7), an appeal of the denial under this subsection must be reviewed  
23 by a licensed health professional to which all of the following  
24 apply:

25 (a) The licensed health professional is knowledgeable of, and  
26 has the same or similar experience providing, the health care  
27 services under appeal.

28 (b) The licensed health professional does not have a direct  
29 financial stake in the outcome of the appeal.

1 (c) The licensed health professional has not been involved in  
2 making the adverse determination.

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

10 (7) An insurer or its designee review organization shall not  
11 affirm the denial of an appeal under subsection (5) unless the  
12 appeal is reviewed by a licensed physician.

13 (8) A prior authorization request under this section that has  
14 not been certified as urgent by the health care provider is  
15 considered granted by the insurer or its designee utilization  
16 review organization if the insurer or its designee utilization  
17 review organization fails to grant the request, deny the request,  
18 or require additional information of the health care provider  
19 within 5 business days after the date and time of submission of the  
20 prior authorization. If additional information is requested by an  
21 insurer or its designee utilization review organization, the prior  
22 authorization request is not considered granted if the health care  
23 provider fails to submit the additional information within 2  
24 business days after the date and time of the request for additional  
25 information. If additional information is requested by an insurer  
26 or its designee utilization review organization, the prior  
27 authorization request is considered to have been granted by the  
28 insurer or its designee utilization review organization if the  
29 insurer or its designee utilization review organization fails to

1 grant the request, deny the request, or otherwise respond to the  
2 request of the health care provider within 5 days after the date  
3 and time of the submission of additional information.

4 (9) A prior authorization request under this section that has  
5 been certified as urgent by the health care provider is considered  
6 granted by the insurer or its designee utilization review  
7 organization if the insurer or its designee utilization review  
8 organization fails to grant the request, deny the request, or  
9 require additional information of the health care provider within 2  
10 business days after the date and time of submission of the prior  
11 authorization request. If additional information is requested by an  
12 insurer or its designee utilization review organization, the prior  
13 authorization request is not considered granted if the health care  
14 provider fails to submit the additional information within 1  
15 business day after the date and time after the request for  
16 additional information. If additional information is requested by  
17 an insurer or its designee utilization review organization, the  
18 prior authorization request is considered to have been granted by  
19 the insurer or its designee utilization review organization if the  
20 insurer or its designee utilization review organization fails to  
21 grant the request, deny the request, or otherwise respond to the  
22 request of the health care provider within 2 days after the date  
23 and time of the submission of additional information.

24 (10) A prior authorization request granted under this section  
25 is valid for not less than 60 calendar days.

26 (11) As used in this section:

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

29 (b) "Evidence-based criteria" means criteria developed using

1 evidence-based standards.

2 (c) "Evidence-based standard" means that term as defined in  
3 section 3 of the patient's right to independent review act, 2000 PA  
4 251, MCL 550.1903.

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

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

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

12 (ii) A health professional.

13 (f) "Health professional" means that term as defined in  
14 section 2006.

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

16 (h) "Licensed physician" means any of the following:

17 (i) A physician licensed to engage in the practice of medicine  
18 under part 170 of the public health code, 1978 PA 368, MCL  
19 333.17001 to 333.17097.

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

23 (iii) A physician licensed in another state.

24 (i) "Peer-reviewed" means the clinical review criteria that is  
25 approved by a committee comprised of clinicians, including licensed  
26 physicians or pharmacists, or both, that meets at regularly-  
27 scheduled intervals and evaluates, among other things,  
28 pharmaceutical literature or medical literature, or both, and  
29 scientific evidence to develop criteria that promotes appropriate,

1 safe, and cost-effective drug utilization.

2 (j) "Prescription drug benefit" means that term as defined in  
3 section 2212c.

4 (k) "Prior authorization" means a determination by an insurer  
5 or utilization review organization that a requested health care  
6 benefit has been reviewed and, based on the information provided,  
7 satisfies the insurer or utilization review organization  
8 requirements for medical necessity and appropriateness.

9 (l) "Standardized electronic prior authorization transaction  
10 process" means a standardized transmission process, identified by  
11 the director and aligned with standards that are nationally  
12 accepted, to enable prior authorization requests to be accessible,  
13 submitted by health care providers, and accepted by insurers or  
14 their designee utilization review organizations electronically  
15 through secure electronic transmissions with the goal of maximizing  
16 administrative simplification, efficiency, and timeliness. The  
17 process must require health care providers to supply clinical  
18 information under the standardized electronic prior authorization  
19 process. Standard electronic prior authorization transaction  
20 process does not include a facsimile.

21 (m) "Urgent" means an insured or enrollee is suffering from a  
22 health condition that may seriously jeopardize the insured's life,  
23 health, or ability to regain maximum function or could subject the  
24 insured or enrollee to severe adverse health consequences that  
25 cannot be adequately managed without the care or treatment that is  
26 the subject of the prior authorization.

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