HOUSE BILL NO. 4707

June 07, 2023, Introduced by Reps. Brabec, Arbit, Neeley, Miller, Breen, Tsernoglou, Hope, Hood, Byrnes, Haadsma, Coffia, Pohutsky, Wegela, McFall, Grant, Conlin, Hill, Paiz, Rheingans, Price, Steckloff, Tyrone Carter, Skaggs, Liberati, Morse, Edwards, Koleszar, Dievendorf, McKinney, Morgan, O'Neal, Scott, Churches, Wilson, Hoskins, MacDonell, Stone, Young and Farhat and referred to the Committee on Insurance and Financial Services.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 2212e and 3425 (MCL 500.2212e and 500.3425), section 2212e as added by 2022 PA 60 and section 3425 as amended by 2016 PA 276.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2212e. (1) For an insurer that delivers, issues for delivery, renews, or administers a health benefit plan in this state, if the health benefit plan requires a prior authorization

with respect to any benefit, the insurer or its designee utilization review organization shall, by June 1, 2023, make available a standardized electronic prior authorization request transaction process utilizing an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system. Beginning June 1, 2023, an insurer described in this subsection or its designee utilization review organization and the health professional shall perform a prior authorization utilizing only a standard electronic prior authorization transaction process, which 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, enrollees, health 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 health care services.

(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) For coverage other than prescription drug benefit coverage, 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. For coverage of a prescription drug benefit, before establishing, or substantially or materially altering, its own clinical review criteria, an insurer or its designee utilization review organization must obtain input from actively practicing

licensed pharmacists or actively practicing licensed physicians. If criteria are developed for a health care service 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 health care service.

(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 under the health benefit plan.

(3) If an insurer described in subsection (1) implements a new prior authorization requirement or restriction, or amends an existing requirement or restriction, with respect to any benefit under a health benefit plan, the insurer shall ensure that the new or amended requirement or restriction is posted on the insurer's public website before its implementation. For a benefit that does not involve coverage of a prescription drug, 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. For coverage of a prescription drug, an insurer shall make available on the insurer's public website or notify contracted health care providers via the insurer's provider portal of the new or amended requirement or restriction not less than 45 days before the requirement or restriction is implemented unless any of the

following apply:

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

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

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

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

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

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

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

(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 health care service 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 insured or enrollee 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 which 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 insured or enrollee'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 disease or provides the health care service. 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 utilize a licensed physician in a similar specialty as considered appropriate, as determined by the insurer or its designee utilization review organization.

(10) Beginning June 1, 2023 through May 31, 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 to grant the request, deny the request, or require additional information of the health care provider within 9 calendar days after the date and time of submission of the prior authorization. After May 31, 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 to grant the request, deny the request, or require additional information of the health care provider within 7 calendar days after the date and time of submission of the prior authorization. Beginning June 1, 2023 through May 31, 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 to grant the request, deny the request, or otherwise respond to the request of the health care provider within 9 calendar days after the date and time of the submission of additional information. After May 31, 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 to grant the request, deny the request, or otherwise respond to the request of the health care provider within 7 calendar days after the date and time of the submission of additional information.

(11) Beginning June 1, 2023, 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 to grant the request, deny the request, or require additional information of the health care provider within 72 hours after the date and time of submission of the prior authorization request. 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 to grant the request, deny the request, or otherwise respond to the request of the health care provider within 72 hours after the date and time of the submission of additional information.

(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, 2023, and each June 1 after that date, an insurer shall report to the department, on a form issued by 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, 2023, 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) For prior authorization of medically necessary treatment of a mental health or substance use disorder, this section is subject to section 3425.

(18) ~~(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 benefit plan" means an individual or group health insurance policy, an individual or group health maintenance organization contract, or a self-funded plan established or maintained by this state or a local unit of government for its employees. Health benefit plan includes prescription drug benefits. Health benefit plan does not include the Medicaid program. As used in this subdivision, "Medicaid program" means the program for medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-6.

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

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

(*ii*) A health professional.

(f) "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.

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

(h) "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.

(i) "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.

(j) "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~~ **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 utilization.

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

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

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

(n) "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.

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

(p) "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.

Sec. 3425. (1) Except as otherwise provided in this subsection, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide

coverage for ~~intermediate and outpatient care for substance use disorder.~~ **medically necessary treatment of a mental health or substance use disorder.** This section does not apply to limited classification policies.

(2) An insurer shall cover the full continuum of service intensities and levels of care that are described in the most recent versions of the following:

(a) The ASAM Criteria by the American Society of Addiction Medicine.

(b) The Level of Care Utilization System by the American Association of Community Psychiatrists.

(c) The Child and Adolescent Level of Care/Service Intensity Utilization System by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry.

(d) Early Child Service Intensity Instrument by the American Academy of Child and Adolescent Psychiatry.

(3) ~~(2)~~ Charges, terms, and conditions for the coverage required to be provided under subsection (1) must not be less favorable than the maximum prescribed for any other comparable service.

(4) ~~(3)~~ The insurer shall not reduce the coverage required to be provided under subsection (1) by terms or conditions that apply to other items of coverage in a health insurance policy, group or individual. This subsection does not prohibit an insurer from providing in a health insurance policy deductibles and copayment provisions for coverage for ~~intermediate and outpatient care for substance use disorder.~~**medically necessary treatment under subsection (1).**

(5) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, an insurer, and any entity acting on the insurer's behalf, shall do all of the following:

(a) Make all medical necessity determinations consistent with current generally accepted standards of mental health and substance use disorder care.

(b) Apply exclusively the level of care placement criteria and practice guidelines set forth in the most recent versions of utilization review criteria and practice guidelines developed by the nonprofit professional association for the relevant clinical specialty within the scope of the criteria. Criteria and guidelines outside the scope of the nonprofit professional association criteria, including criteria described in section 2212e, may be used if the criteria are fully consistent with current generally accepted standards of mental health and substance use disorder care.

(c) Not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment at any level of care placement.

(6) Except as otherwise provided in subsection (5), a prior authorization determination for mental health and substance abuse disorder services must be conducted under section 2212e.

(7) For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the insured's assessment using the relevant nonprofit professional association level of care placement criteria and guidelines under subsection (5)(b). If that level of placement is not available, the

insurer shall authorize the next higher level of care. If there is a disagreement between the insured's provider and the insurer, the insurer shall provide full detail of its scoring using the relevant level of care placement criteria and guidelines to the insured and the insured's provider.

(8) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timeliness access standards under law, the insurer shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. The insured shall pay not more in total for benefits rendered than the cost sharing that the insured would pay for the same covered services received from an in-network provider.

(9) For an adverse determination regarding a mental health or substance use disorder service, including an adverse determination regarding a prior authorization under section 2212e, the reviewer must have the appropriate training and relevant experience in the clinical specialty involved in the coverage determination. As used in this subsection, "adverse determination" means that term as defined in section 2213.

(10) An insurer shall cover mental health and substance use disorder emergency services not more restrictively and using the same coverage standards as for other emergency services, including, but not limited to, utilizing the prudent layperson standard and not applying prior authorization. The insured shall pay not more than the in-network cost sharing amount regardless of provider participation status.

(11) An insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public program. As used in this subsection:

(a) "Medicaid" means a program for medical assistance established under subchapter XIX of the social security act, 42 USC 1396 to 1396w-6.

(b) "Medicare" means the federal Medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(c) "Social Security Disability Insurance" means disability insurance under 42 USC 423 to 425.

(d) "Supplemental Security Income" means the program authorized under title XVI of the social security act, 42 USC 1381 to 1383f.

(12) An insurer that authorizes a specific type of treatment by a provider under this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and under this authorization for any reason, including, but not limited to, the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract, or the insurer's subsequent determination that it did not make an accurate determination of the insured's or policyholder's eligibility.

(13) An insurer shall not adopt, impose, or enforce terms in

its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(14) This section does not apply to any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(15) By March 1, 2024, and each March 1 after that date, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall submit a report to the director that includes the comparative analyses and other information regarding the design and application of nonquantitative treatment limitations that apply to mental health or substance use disorder benefits required by 42 USC 300gg-26(a)(8)(A).

(16) If the director determines that an insurer or any entity or person acting on the insurer's behalf has violated this section, the director shall, after appropriate notice and opportunity for hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, by order, assess a civil penalty of $5,000.00 for each violation. If an insurer or any entity or person acting on the insurer's behalf knew or reasonably should have known that the action was in violation of this act, the director shall assess a civil penalty of $10,000.00 for each violation. The civil penalties available to the director under this section are not exclusive and may be sought and employed in combination with any other remedies available to the director under this act.

(17) ~~(4)~~ As used in this section:

~~(a) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following~~

~~therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent on or abusing alcohol or drugs:~~

~~(*i*) Chemotherapy.~~

~~(*ii*) Counseling.~~

~~(*iii*) Detoxification services.~~

~~(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in the treatment plan.~~

~~(b) "Limited classification policy" means an accident only policy, a limited accident policy, a travel accident policy, or a specified disease policy.~~

~~(c) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent on or abusing alcohol or drugs:~~

~~(*i*) Chemotherapy.~~

~~(*ii*) Counseling.~~

~~(*iii*) Detoxification services.~~

~~(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in the treatment plan.~~

~~(d) "Substance use disorder" means that term as defined in section 100d of the mental health code, 1974 PA 258, MCL 330.1100d.~~

(a) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry,

psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(b) "Limited classification policy" means an accident-only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

(c) "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(*i*) In accordance with the generally accepted standards of mental health and substance use disorder care.

(*ii*) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(*iii*) Not primarily for the economic benefit of the insurer or purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(d) "Mental health and substance use disorder" means a mental health condition or substance use disorder that falls under any of

the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

(e) "Mental health and substance use disorder emergency services" means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services. As used in this subdivision, "988 center" means a center operating in this state that participates in the National Suicide Prevention Lifeline network to respond to 988 calls.

(f) "Utilization review" means either of the following:

(*i*) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively, or concurrently with the provision of health care services to insureds.

(*ii*) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an

insurance policy is covered as medically necessary for an insured.

(g) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.