STATE OF MICHIGAN
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DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
LANSING

ANITA G. FOX
DIRECTOR

To: Members of the House Health Policy Committee

From: Joseph Sullivan, Insurance Legislative Liaison

Date: March 3, 2022

Re: Senate Bill 247 (S-3)

Thank you for the opportunity to weigh in on Senate Bill 247 (S-3). My apologies for not being in attendance today, I had a scheduling conflict. However, I plan to attend the next hearing and am always available to answer member questions.

SB 247 aims to reform the prior authorization process by establishing additional requirements upon health insurers. Specifically, the bill would:

- Streamline the prior authorization request process to ensure patients receive timely care.
- Ensure that prior authorization requests and denials are made by licensed medical providers and are based upon high standards to ensure quality of care.
- Provide transparency regarding prior authorizations through annual reporting and by providing readily available information on the insurer's website.

DIFS believes that the reforms proposed by SB 247 would improve patient care. The new requirements in the bill would reduce the wait times for prior authorization requests and allow providers to administer care to patients faster, especially in cases where medical care is urgent.

During our internal review process, DIFS was able to identify the following concerns, and we appreciate any consideration for these changes:

- **Sec. 2212c(1):** references a prior authorization's request for expedited review and replaces a reference to the 15-day standard review period with a reference to a "5 business day review period." It may be confusing to keep references to "expedited reviews" because they appear linked to subsections 2212c(8) and (9), which are being struck. Furthermore, this language appears to create a standard for measuring whether expedited review is justified, and that standard seems to overlap with the definition of "urgent" that is used in section 2212e to assess whether a shortened review period is justified. This has the potential to further add confusion.

- **Sec. 2212c(8)(b):** The definition of "insurer" references third-party administrators (TPA) that administer prescription drug benefits, whereas section 2212e applies to insurers with plans requiring prior authorization with respect to any benefits. Thus, this description of the TPA may be too narrow. This may not cause practical problems if all TPAs necessarily, in practice, would fit within the description as an administrator of prescription drug benefits, however, the definition should be clarified.

    - Given the changes in PA 12'22 and the language of Sec. 2212e, Sec. 2212c: (8)(b) can be changed to just “A third party administrator” instead of “A third party administrator of prescription drug benefits” or just cite the new definition directly from MCL 550.902.

- **Sec. 2212e(1):** clarify the prior authorization information requirements that are to be conveyed to the insured. The prior authorization requirements should be written into, or appended to, the contract, and a link to the website should be required.

- **Sec. 2212e(3) subdivisions (a) to (c)** are exceptions to an insurer's duty to give providers notice of a change or new prior authorization requirement or restriction. It's not clear how the circumstances in these subdivisions relate to excusing that notice. The concern is that these circumstances are intended to prevent the change in requirements/restrictions, and that is not what the language does.
    - Language should be changed to make clear that insurers are not exempt from notifying providers of changes to prior auth requirements when the exceptions in subdivisions (a) to (c) occur, but rather more specifically that they are exempt from the 60 or 45 day requirement.

- **Sec. 2212e(3):** Require insurers to provide notice to insureds of any new or amended prior authorization requirements. The bill currently requires an insurer to post any new prior authorization requirements on its website and to notify health care providers. Insureds should be updated as well (by rider or notice to the insureds).

- **Sec. 2212e(8):** the health professional review under this subsection is mandatory; however, it does not contain the "teeth" provided in subsection (9) that if the review fails to occur, the insurer or utilization review organization cannot affirm the "denial." Because subsection (9) includes that language, the issue for subsection (8) is there are no consequences for failing to have a health professional review the appeal.

- **Sec. 2212e(13):** should be amended to require insurers to submit information on a form issued by DIFS.

As various provisions in the bill are still being discussed and worked out by stakeholders, DIFS currently has a position of **“neutral”** on the bill.

Thank you for your consideration. If you have any questions, please contact me at 517-449-9515 or at sullivanj15@michigan.gov.

Sincerely,

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