Michigan's New Prior Authorization Reforms Take Effect June 1; National Efforts Underway

In April 2022, Gov. Gretchen Whitmer signed bipartisan legislation into law to reform Michigan's prior authorization process. Key features of Senate Bill 247 of 2022, now **Public Act 60 of 2022**, shorten wait times, increase transparency, and streamline how physician offices and payers interact. The ultimate goal: increase access to care by ensuring patients can get the medication and treatment they need, when they need it, as determined by their physician.

Passage of this historic bill was the culmination of years of advocacy work by Michigan Academy of Family Physicians, members of the family medicine community, patients, and other partners of the Health Can't Wait coalition.

What Family Physicians Should Know

Provisions of Public Act 60 apply to healthcare insurers and professionals with commercial insurance policies regulated by the Michigan Department of Insurance and Financial Services. The law does not impact Medicaid, Medicare, Medicare Advantage, or self-funded plans.

Beginning June 1, 2023, insurers must:

- Provide a standardized online option for submitting prior authorization requests for any benefits, including prescription medications. Physicians and healthcare professionals must submit prior authorization requests electronically, except in instances of technological or electrical failure.

- Base prior authorization requirements on peer-reviewed clinical review criteria that takes into account atypical populations, reflects a community standard of care, is publicly available free of charge, and is evaluated and updated at least annually.

- Post prior authorization requirements and changes online, prior to taking effect.

- Deem an approved request valid for at least 60 calendar days or for a duration that is clinically appropriate, whichever is later.

- On issuing a medical benefit denial, notify the healthcare professional and insured/enrollee of the evidence-based reason and the right to appeal the denial.

- For a medical benefit that is not a prescription drug benefit, notify contracted healthcare providers via the insurer's provider portal of new or amended requirements/restrictions not less than 60 days before implementation.

- For a prescription drug benefit, notify contracted healthcare providers via the insurer's provider portal of new or amended requirements/restrictions not less than 45 days before implementation.

- Not affirm the denial of an appeal unless the appeal was reviewed by a licensed physician with clinical experience in the corresponding specialty.

- Act on urgent prior authorization requests within 72 hours or they are automatically approved.

- Act on non-urgent requests within 9 calendar days of the original submission or the prior authorization is considered granted. After May 31, 2024, non-urgent prior authorizations are considered granted if the insurer fails to act within 7 calendar days of the original submission.

- Adopt a "gold card" program that promotes the modification of prior authorization requirements of certain prescription drugs, medical care, or related benefits, based on the performance of the healthcare providers with respect to adherence to nationally recognized evidence-based medical guidelines and other quality criteria.

AAFP's Prior Authorization Reform Work

At the national level, reforming the prior authorization process has been a top priority of American Academy of Family Physicians for quite some time. AAFP's advocacy work recently achieved a win when the Centers for Medicare and Medicaid Services finalized a 2024 Medicare Advantage and part D rule that, among other things, introduces continuity of care requirements, bolsters access to behavioral health services, improves coverage criteria, increases transparency of determinations, and prevents inappropriate coverage denials.

READ MORE