

HOUSE SUBSTITUTE FOR
SENATE BILL NO. 247

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~~ review period **under**
 3 **section 2212e(10)** may seriously jeopardize the life or health of
 4 the 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.~~that delivers, issues for**
6 **delivery, renews, or administers a health benefit 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~~For purposes of this section and section 2212e only, a**
12 **third party administrator of prescription drug benefits. As used in**
13 **this subparagraph, "third party administrator" means that term as**
14 **defined in section 2 of the third party administrator act, 1984 PA**
15 **218, MCL 550.902.**

16 **(c) ~~(b)~~"Prescriber" means that term as defined in section**
17 **17708 of the public health code, 1978 PA 368, MCL 333.17708.**

18 **(d) ~~(e)~~"Prescription drug" means that term as defined in**
19 **section 17708 of the public health code, 1978 PA 368, MCL**
20 **333.17708.**

21 **(e) ~~(d)~~"Prescription drug benefit" means the right to have a**
22 **payment made by an insurer ~~pursuant to prescription drug~~for a**
23 **prescription drug listed on the applicable formulary in accordance**
24 **with coverage contained within a ~~policy, certificate, or contract~~**
25 **health benefit plan delivered, issued for delivery, or renewed in**
26 **this state.**

27 **(f) ~~(e)~~"Workgroup" means the prescription drug prior**
28 **authorization workgroup created under subsection (2).**

29 **Sec. 2212e. (1) For an insurer that delivers, issues for**

1 delivery, renews, or administers a health benefit plan in this
2 state, if the health benefit plan requires a prior authorization
3 with respect to any benefit, the insurer or its designee
4 utilization review organization shall, by June 1, 2023, make
5 available a standardized electronic prior authorization request
6 transaction process utilizing an internet webpage, internet webpage
7 portal, or similar electronic, internet, and web-based system.
8 Beginning June 1, 2023, an insurer described in this subsection or
9 its designee utilization review organization and the health
10 professional shall perform a prior authorization utilizing only a
11 standard electronic prior authorization transaction process, which
12 allows the transmission of clinical information, unless the health
13 professional is not able to use the standard electronic prior
14 authorization transaction process because of a temporary
15 technological or electrical failure. The current prior
16 authorization requirements must be described in detail and written
17 in easily understandable language. An insurer described in this
18 subsection or its designee utilization review organization shall
19 make any current prior authorization requirements and restrictions,
20 including the written clinical review criteria, readily accessible
21 and conspicuously posted on its website to insureds, enrollees,
22 health professionals, and health care providers. Content published
23 by a third party and licensed for use by an insurer described in
24 this subsection or its designee utilization review organization may
25 be made available through the insurer or its designee utilization
26 review organization's secure, password-protected website if the
27 access requirements of the website do not unreasonably restrict
28 access to the content. The prior authorization requirements must be
29 based on peer-reviewed clinical review criteria. All of the

1 following apply to clinical review criteria under this subsection:

2 (a) Unless the criteria are developed as described in
3 subdivision (g), the clinical review criteria must be criteria
4 developed by either of the following:

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

6 (A) The entity works directly with clinicians, either within
7 the organization or outside the organization, to develop the
8 clinical review criteria.

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

11 (ii) A professional medical specialty society.

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

14 (c) The clinical review criteria must ensure quality of care
15 and access to needed health care services.

16 (d) The clinical review criteria must be evidence-based
17 criteria.

18 (e) The clinical review criteria must be sufficiently flexible
19 to allow deviations from norms when justified on a case-by-case
20 basis.

21 (f) The clinical review criteria must be evaluated and
22 updated, if necessary, at least annually.

23 (g) For coverage other than prescription drug benefit
24 coverage, before establishing, or substantially or materially
25 altering, its own written clinical review criteria, an insurer or
26 its designee utilization review organization must obtain input from
27 actively practicing licensed physicians representing major areas of
28 the specialty. For coverage of a prescription drug benefit, before
29 establishing, or substantially or materially altering, its own

1 clinical review criteria, an insurer or its designee utilization
2 review organization must obtain input from actively practicing
3 licensed pharmacists or actively practicing licensed physicians. If
4 criteria are developed for a health care service provided by a
5 health professional not licensed to engage in the practice of
6 medicine under part 170 of the public health code, 1978 PA 368, MCL
7 333.17001 to 333.17097, or osteopathic medicine and surgery under
8 part 175 of the public health code, 1978 PA 368, MCL 333.17501 to
9 333.17556, an insurer or designee utilization review organization
10 must also seek input from a health professional in the same
11 profession as the health professional providing the health care
12 service.

13 (2) An insurer described in subsection (1) shall make
14 available on the insurer's public website in a readily accessible
15 format a list of all benefits that are subject to a prior
16 authorization under the health benefit plan.

17 (3) If an insurer described in subsection (1) implements a new
18 prior authorization requirement or restriction, or amends an
19 existing requirement or restriction, with respect to any benefit
20 under a health benefit plan, the insurer shall ensure that the new
21 or amended requirement or restriction is posted on the insurer's
22 public website before its implementation. For a benefit that does
23 not involve coverage of a prescription drug, an insurer shall
24 notify contracted health care providers via the insurer's provider
25 portal of the new or amended requirement or restriction not less
26 than 60 days before the requirement or restriction is implemented.
27 For coverage of a prescription drug, an insurer shall make
28 available on the insurer's public website or notify contracted
29 health care providers via the insurer's provider portal of the new

1 or amended requirement or restriction not less than 45 days before
2 the requirement or restriction is implemented unless any of the
3 following apply:

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

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

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

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

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

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

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

17 (4) The initial review of information submitted in support of
18 a request for prior authorization may be conducted and approved by
19 a health professional.

20 (5) For an adverse determination regarding a request for prior
21 authorization for a benefit other than a prescription drug, the
22 adverse determination must be made by a licensed physician. For an
23 adverse determination of a health care service provided by a health
24 professional that is not a licensed physician, a licensed physician
25 may consider input from a health professional who is in the same
26 profession as the health professional providing the health care
27 service. The licensed physician shall make the adverse
28 determination under this subsection under the general direction of
29 the insurer's medical director who oversees the utilization

1 management program. Medical directors under this subsection must be
2 licensed to engage in the practice of medicine under part 170 of
3 the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or
4 the practice of osteopathic medicine and surgery under part 175 of
5 the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

6 (6) For an adverse determination regarding a request for prior
7 authorization for a prescription drug, the adverse determination
8 must be made by a licensed pharmacist or licensed physician. The
9 licensed pharmacist or licensed physician shall make the adverse
10 determination under this subsection under the general direction of
11 the insurer's medical director who oversees the utilization
12 management program. Medical directors under this subsection must be
13 licensed to engage in the practice of medicine under part 170 of
14 the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or
15 the practice of osteopathic medicine and surgery under part 175 of
16 the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

17 (7) 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 benefit denial, notify the health
20 professional and insured or enrollee of all of the following:

21 (a) The reasons for the denial and related evidence-based
22 criteria.

23 (b) The right to appeal the adverse determination.

24 (c) Instructions on how to file the appeal.

25 (d) Additional documentation necessary to support the appeal.

26 (8) Subject to subsection (9) an appeal of the denial under
27 subsection (7) must be reviewed by a health professional to which
28 all of the following apply:

29 (a) The health professional does not have a direct financial

1 stake in the outcome of the appeal.

2 (b) The health professional has not been involved in making
3 the adverse determination.

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

11 (d) The health professional may consider input from a health
12 professional who is licensed in the same profession as the health
13 professional providing the health care service or a licensed
14 pharmacist if the adverse decision is regarding a prescription
15 drug.

16 (9) An insurer or its designee utilization review organization
17 shall not affirm the denial of an appeal under subsection (8)
18 unless the appeal is reviewed by a licensed physician who is board
19 certified or eligible in the same specialty as a health care
20 provider who typically manages the medical condition or disease or
21 provides the health care service. However, if an insurer or its
22 designee utilization review organization cannot identify a licensed
23 physician who meets the requirements described in this subsection
24 without exceeding the applicable time limits imposed under
25 subsection (10), the insurer or its designee utilization review
26 organization may utilize a licensed physician in a similar
27 specialty as considered appropriate, as determined by the insurer
28 or its designee utilization review organization.

29 (10) Beginning June 1, 2023 through May 31, 2024, a prior

1 authorization request under this section that has not been
2 certified as urgent by the health care provider is considered
3 granted by the insurer or its designee utilization review
4 organization if the insurer or its designee utilization review
5 organization fails to grant the request, deny the request, or
6 require additional information of the health care provider within 9
7 calendar days after the date and time of submission of the prior
8 authorization. After May 31, 2024, a prior authorization request
9 under this section that has not been certified as urgent by the
10 health care provider is considered granted by the insurer or its
11 designee utilization review organization if the insurer or its
12 designee utilization review organization fails to grant the
13 request, deny the request, or require additional information of the
14 health care provider within 7 calendar days after the date and time
15 of submission of the prior authorization. Beginning June 1, 2023
16 through May 31, 2024, if additional information is requested by an
17 insurer or its designee utilization review organization, the prior
18 authorization request is considered to have been granted by the
19 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 9 calendar days after
23 the date and time of the submission of additional information.
24 After May 31, 2024, if additional information is requested by an
25 insurer or its designee utilization review organization, the prior
26 authorization request is considered to have been granted by the
27 insurer or its designee utilization review organization if the
28 insurer or its designee utilization review organization fails to
29 grant the request, deny the request, or otherwise respond to the

1 request of the health care provider within 7 calendar days after
2 the date and time of the submission of additional information.

3 (11) Beginning June 1, 2023, a prior authorization request
4 under this section that has been certified as urgent by the health
5 care provider is considered granted by the insurer or its designee
6 utilization review organization if the insurer or its designee
7 utilization review organization fails to grant the request, deny
8 the request, or require additional information of the health care
9 provider within 72 hours after the date and time of submission of
10 the prior authorization request. If additional information is
11 requested by an insurer or its designee utilization review
12 organization, the prior authorization request is considered to have
13 been granted by the insurer or its designee utilization review
14 organization if the insurer or its designee utilization review
15 organization fails to grant the request, deny the request, or
16 otherwise respond to the request of the health care provider within
17 72 hours after the date and time of the submission of additional
18 information.

19 (12) A prior authorization request granted under this section
20 is valid for not less than 60 calendar days or for a duration that
21 is clinically appropriate, whichever is later.

22 (13) By June 1, 2023, and each June 1 after that date, an
23 insurer shall report to the department, on a form issued by the
24 department, the following aggregated trend data related to the
25 insurer's prior authorization practices and experience for the
26 prior plan year:

- 27 (a) The number of prior authorization requests.
28 (b) The number of prior authorization requests denied.
29 (c) The number of appeals received.

1 (d) The number of adverse determinations reversed on appeal.

2 (e) Of the total number of prior authorization requests, the
3 number of prior authorization requests that were not submitted
4 electronically.

5 (f) The top 10 services that were denied.

6 (g) The top 10 reasons prior authorization requests were
7 denied.

8 (14) By October 1, 2023, and each October 1 after that date,
9 the department shall aggregate and deidentify the data collected
10 under subsection (13) into a standard report and shall not identify
11 the name of the insurer that submitted the data. The report must be
12 written in easily understandable language and posted on the
13 department's public internet website.

14 (15) All of the following apply to any data, documents,
15 materials, or other information described in subsection (13) that
16 has not been aggregated, deidentified, and otherwise compiled into
17 the standard report described in subsection (14):

18 (a) The data, documents, materials, or other information is
19 considered proprietary and to contain trade secrets.

20 (b) The data, documents, materials, or other information is
21 confidential and privileged and is not subject to disclosure under
22 the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

23 (16) An insurer described in subsection (1) shall adopt a
24 program, developed in consultation with health care providers
25 participating with the insurer, that promotes the modification of
26 prior authorization requirements of certain prescription drugs,
27 medical care, or related benefits, based on any of the following:

28 (a) The performance of health care providers with respect to
29 adherence to nationally recognized evidence-based medical

1 guidelines, appropriateness, efficiency, and other quality
2 criteria.

3 (b) Involvement of contracted health care providers with an
4 insurer described in subsection (1) to participate in a financial
5 risk-sharing payment plan, that includes downside risk.

6 (c) Health provider specialty, experience, or other factors.

7 (17) As used in this section:

8 (a) "Adverse determination" means that term as defined in
9 section 2213.

10 (b) "Evidence-based criteria" means criteria developed using
11 evidence-based standards.

12 (c) "Evidence-based standard" means that term as defined in
13 section 3 of the patient's right to independent review act, 2000 PA
14 251, MCL 550.1903.

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

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

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

26 (ii) A health professional.

27 (f) "Health professional" means an individual licensed,
28 registered, or otherwise authorized to engage in a health
29 profession under article 15 of the public health code, 1978 PA 368,

1 MCL 333.16101 to 333.18838, or under the laws of another state to
2 engage in a health profession.

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

4 (h) "Licensed pharmacist" means either of the following:

5 (i) A pharmacist licensed to engage in the practice of pharmacy
6 under part 177 of the public health code, 1978 PA 368, MCL
7 333.17701 to 333.17780.

8 (ii) A pharmacist licensed in another state.

9 (i) "Licensed physician" means any of the following:

10 (i) A physician licensed to engage in the practice of medicine
11 under part 170 of the public health code, 1978 PA 368, MCL
12 333.17001 to 333.17097.

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

16 (iii) A physician licensed in another state.

17 (j) "Peer-reviewed" means the clinical review criteria that is
18 approved by a committee comprised of clinicians, including licensed
19 physicians or licensed pharmacists, or both, that meets at
20 regularly-scheduled intervals and evaluates, among other things,
21 pharmaceutical literature or medical literature, or both, and
22 scientific evidence to develop criteria that promotes appropriate,
23 safe, and cost-effective drug utilization.

24 (k) "Prescription drug" means that term as defined in section
25 2212c.

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

28 (m) "Prior authorization" means a determination by an insurer
29 or utilization review organization that a requested health care

1 benefit has been reviewed and, based on the information provided,
2 satisfies the insurer or utilization review organization
3 requirements for medical necessity and appropriateness.

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

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

22 (p) "Utilization review organization" means that term as
23 defined in section 3 of the patient's right to independent review
24 act, 2000 PA 251, MCL 550.1903.