SB688_PrescriptionAppeals_KennedyKrieger_Support.p
Uploaded by: Emily Arneson
Position: FAV

Kennedy Krieger Institute

DATE: **February 23, 2022** **COMMITTEE: Senate Finance**
BILL NO: **Senate Bill 688**
BILL TITLE: **Health Insurance - Utilization Review for Coverage of Prescription Drugs and Devices - Expedited Appeals**
POSITION: **Support**

Kennedy Krieger Institute supports Senate Bill 688 - Health Insurance - Utilization Review for Coverage of Prescription Drugs and Devices - Expedited Appeals

Bill Summary:

Senate Bill 688 establishes certain requirements on utilization review of prescription drug and device coverage and expedites appeal when a prescription drug or device has been denied coverage.

Background:

Kennedy Krieger Institute provides specialized services to patients nationally and internationally. Kennedy Krieger Institute is dedicated to improving the lives of children and young adults with developmental, behavioral, cognitive and physical challenges. Kennedy Krieger's services include inpatient, outpatient, school-based and community-based programs.

Rationale:

The current process for utilization review of prescription drugs and devices has been a barrier for access to care for the patient population served at Kennedy Krieger. These requirements often disproportionately affect patients with developmental disabilities and complex medical needs who have an increased risk of experiencing serious adverse effects with delay for treatment.

Healthcare providers across all disciplines have remained highly focused on providing optimal care during the COVID pandemic and resulting disruptions to standard mechanisms for care. During this time, especially, the excessive paperwork and increased utilization of remote work by authorizing agencies has make it even more difficult for providers to get timely responses when requesting coverage, ultimately delaying care.

It is appropriate that prescription authorizations could also be expedited by allowing the review of reconsideration of approval to be completed by a provider who is of same specialty, and therefore familiar with the risk of delaying access to the drug or device. This congruence of specialty is especially important for patients with rare diseases and/or uncommon presentations of common diseases.

Additionally, should a patient change insurance providers, the new insurance provider often requests authorization prior to agreeing to cover the prescription. This action can harm a patient who is medically stable in their current regime when a prescription is not available to be filled in a timely fashion. The provision in SB688 D(2) disallowing utilization review for a prescription drug that has been prescribed uninterrupted for 6 months or more is a key mechanism to prevent this sort of unwarranted and potentially harmful interruption in care.

Kennedy Krieger Institute requests a favorable report on Senate Bill 688.

SB688 Testimony PDF.pdf
Uploaded by: JENNIFER PALMER
Position: FAV

Jennifer Teitelbaum Palmer M.D.
General Adult Psychiatry & Women's Mood Disorders
P.O. Box 50340, Baltimore, MD 21211
410-929-1311 (tel) 443-568-0700 (fax) jtpalmer.com (web)

February 22, 2022

Dear Committee Chair Kelley:

I am writing as a practicing psychiatrist and member of the Maryland Psychiatric Society in favor of SB688.

Prior authorization is a practice by which insurers refuse to pay for medications at the point of sale and ask the prescribing physician to justify their prescriptions. This takes time away from patient care and prevents patients from filling prescriptions in a timely manner. Often patients are forced to pharmacy-shop, using coupons to cover the cost the insurers will not.

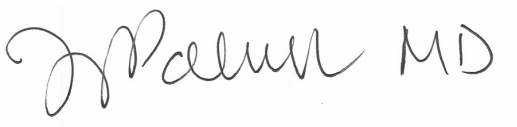
Prior authorization is purported to be a cost-containing measure but in reality, insurers are practicing medicine without a license in service of their own financial interests. Common, generic drugs are being denied coverage while some newer and more expensive medications are favored. For example, some plans refuse to cover generic fluoxetine in favor of brand name Trintellix. This make no sense from a cost-saving perspective unless the insurer has a deal with the Trintellix manufacturer.

Insurers also often require new authorization every time the dose of a medication is changed. This makes no sense medically and prevents patients from getting the doses their doctors prescribe.

Finally, even when a plan-employed physician denies coverage, they often practice a different specialty than the prescribing doctor, and do not know the best practices of that specialty.

This bill would prohibit insurers from imposing these burdens on doctors and their patients. Please give SB688 a favorable report. Thank you for your consideration of this testimony.

Respectfully submitted,



Jennifer Palmer, M.D.

2-3-22_MPS_Prior Authorization One-Pager (002).pdf
Uploaded by: Justin Ready
Position: FAV

Help healthcare clinicians deliver timely patient care

Support common sense prior authorization reform

AMERICAN PSYCHIATRIC ASSOCIATION

Washington Psychiatric Society

Prior authorization impacts access to mental health care

Nearly 1 in 5 Americans report having a mental illness, and it's gotten worse during the COVID-19 pandemic. For psychiatric patients, gaps in treatment due to prior authorization can lead to relapse, with increased health care costs and devastating effects for individuals and their families.

We must contain prior authorization to ensure patients have access to timely medications.

What is prior authorization?

Prior authorization is a utilization management tool that requires doctors to obtain approval from an insurance plan or pharmacy benefit manager (PBM) before it will cover the costs of a specific medicine, medical device, or procedure.

90% of physicians report that prior authorization has a significantly negative impact on patient outcomes.

Prior authorization is harmful to patients because:

it results in patients experiencing arbitrary limits on medications.

delays to lifesaving treatment can cause patient symptoms to quickly worsen.

it limits time with their physician due to extensive paperwork and long telephone wait times.

Support legislation that:

- eliminates prior authorization for:
  - » generic medications that are not controlled substances.
  - » dosage changes of the same medication.
  - » generic and brand drugs after six months of adherence.
- requires that insurers and PBMs adhere to a 48-hour appeal process.
- prohibits plans from denying medication on the grounds of therapeutic duplication.
- requires denials and denial reviews be conducted by physicians in the same or similar specialty as the clinician whose treatment is under review.

AmendmentSB0688-663329-01 (003).pdf
Uploaded by: Justin Ready
Position: FAV

SB0688/663329/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

11 FEB 22
09:58:40

BY: Senator Ready
(To be offered in the Finance Committee)

AMENDMENT TO SENATE BILL 688
(First Reading File Bill)

On page 1, after line 20, insert:

"**(A) THIS SECTION MAY NOT BE CONSTRUED TO ALTER OR NULLIFY THE REQUIREMENTS RELATING TO AN ONLINE PREAUTHORIZATION SYSTEM FOR ELECTRONIC PREAUTHORIZATION REQUESTS UNDER § 19–108.2 OF THE HEALTH – GENERAL ARTICLE.**";

and in line 21, strike "**(A)**" and substitute "**(B)**".

On page 2, in lines 12 and 24, strike "**(B)**" and "**(C)**", respectively, and substitute "**(C)**" and "**(D)**", respectively.

On page 3, in line 23, strike "**(D)**" and substitute "**(E)**".

ExpeditedAppealSB688Testimony2022docx (1).pdf
Uploaded by: Justin Ready
Position: FAV

Justin Ready
Legislative District 5
Carroll County

Minority Whip

Finance Committee

James Senate Office Building
11 Bladen Street, Room 315
Annapolis, Maryland 21401
410-841-3683 · 301-858-3683
800-492-7122 *Ext.* 3683
Justin.Ready@senate.state.md.us

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

February 23, 2022

Senate Bill 688- Health Insurance - Utilization Review for Coverage of Prescription Drugs and Devices - Expedited Appeals

Chairwoman Kelley, Vice Chair Feldman and member of the Finance Committee,

When a physician or other clinician prescribes medication or treatment for a patient, the patient's insurance company or pharmaceutical benefits manager (PBM) requires prior authorization before approving coverage. While prior authorization is promoted as a health care savings mechanism[i], this process allows insurers and PBMs to impose extensive paperwork requirements, multiple phone calls, and significant wait times on both prescribers and their patients.

As Maryland physicians continue to be overwhelmed by the pandemic and the need for mental health treatment grows, eliminating these burdensome requirements would alleviate a fraction of their stress and enable them to spend more time with patients in need. Prior authorization often leads to patients experiencing arbitrary limits on medications. When insurers and PBMs decide that patients should not get the treatment physicians have recommended, this is akin to practicing medicine without a license.

Remarkably, there is no clear evidence that prior authorization either improves the quality of patient care or saves money[ii]. Instead, it often results in unnecessary delays in receiving life-sustaining medications or other treatments and leads to physicians spending more time on paperwork and less time treating their patients. For individuals with psychiatric disorders, including those with serious mental illness or substance use disorders, gaps in treatment due to pre-authorization denials can lead to relapse, with increased health care costs and devastating effects for individuals and their families.

This bill would:

1) **eliminate prior authorization for generic medications that are not controlled substances.** These medications are cheap and not addictive; therefore, prior authorization provides no benefit to costs or patient safety.
2) **eliminate prior authorization for dosage strength changes of the same medication**. Patients may often require a dosage adjustment and prescribers should not be constricted by administrative barriers to use their professional judgement.

3) **eliminate prior authorization for generic and brand drugs after patients have been on the medication for six months without interruption.** Once a patient has demonstrated a stable adherence to their treatment plan, his or her prescriber should not be subjected to additional prior authorizations.
4) **require insurers and PBMS adhere to a 48-hour appeal process to ensure timely access to medications for patients.** Too often, patients may suffer serious harm without access to their medication while they wait for insurers or PBMs to approve their medication coverage. For those medications still subject to review, it is imperative that insurers and PBMs provide a timely response to ensure continuity of care.
5) **prohibit plans from denying medication on the grounds of therapeutic duplication if the patient has already been subject to review for the same dosage and it was previously approved.** When a patient requires a certain dosage of medication that is not manufactured in that specific dosage, prescribers may write two corresponding prescriptions to create a unique dose for the patient. Patients are often denied coverage of this medication based on "therapeutic duplication," without recognizing the patient's dosing needs.
6) **require denials and denial reviews be conducted by physicians in the same profession or similar specialty as the health care provider whose recommended treatment is under review.** Insurers and PBMs have been empowered to practice medicine without a license to make coverage denials. Even when a physician is conducting utilization reviews, a psychiatrist may receive a denial from a cardiologist, who lacks the clinical expertise. This change would ensure that denial and denial reviews are overseen by an expert who is familiar with the treatment plan and type of patient under review.

In conclusion, patients need timely access to medication. Please support legislation that makes common sense changes to prior authorization. I urge a favorable on Senate Bill 688.

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[i] American Medical Association. *2021 AMA Prior Authorization (PA) Physician Survey.* 2021.

[ii] American Medical Association. *Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitative analysis of physician and staff interviews.* October 2016.

Prior auth reforms - issue brief21 (002).pdf
Uploaded by: Justin Ready
Position: FAV

AMA AMERICAN MEDICAL ASSOCIATION

Advocacy Resource Center

Advocating on behalf of physicians and patients at the state level

It is time to fix prior authorization

Prior authorization is hurting patients

- 93% of physicians report **care delays** as a result of prior authorizations.
- 82% of physicians report that prior authorization can lead to **treatment abandonment.**
- 34% of physician reported that prior authorization has led to a **serious adverse event** for their patients.
- 24% of physicians reported that prior authorization has led to a patient's **hospitalization**.
- 18% of physicians reported **life-threatening event or intervention to prevent permanent impairment or damage.**
- 51% of physicians treating patients in the workforce report that prior authorization has **interfered with a patient's ability to perform their job responsibilities.**

Prior authorization is costly

- Physicians and their staff spend more than 13 hours/week (nearly two business days) on prior authorizations.
- Physicians complete an average of 41 prior authorizations per week.
- 40% of physicians have staff who work exclusively on prior authorizations.
- 88% of physicians describe the prior authorization burden as high or extremely high.

What can be done?

As a start to fixing prior authorization, policymakers and other stakeholders should consider how the volume of prior authorization is impacting patients, physicians and the health care system. While these programs may reduce the amount health insurers are paying on care in the short-term, delaying or denying medically necessary care is not an appropriate or effective long-term solution to reducing costs. **Prior authorization, if used at all, must be used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians and other providers.**

Policymakers should consider the following **prior authorization reforms**:

- Establish quick response times (24 hours for urgent, 48 hours for non-urgent care).
- Adverse determinations should be made only by a physician licensed in the state and of the same specialty that typically manages the patient's condition.
- Prohibit retroactive denials if care is preauthorized.
- Authorization should be valid for at least 1 year, regardless of dose changes, and for those with chronic conditions, the prior authorization should be valid for the length of treatment.
- Require public release of insurers' prior authorization data by drug and service as it relates to approvals, denials, appeals, wait times and more.
- A new plan should honor the patient's prior authorization for at least 60 days.
- Volume reduction through the use of solutions like prior authorization exemptions or gold-carding programs.

For more info contact Emily Carroll at emily.carroll@ama-assn.org.

*Data comes from the 2021 AMA Prior Authorization Physician Survey. For more information on the survey, to access prior authorization resources, and to join our grassroots campaign, visit fixpriorauth.org.

SB688 Sponsor Witness Signup Form_2022.pdf
Uploaded by: Justin Ready
Position: FAV

Senate Standing Committee
Sponsor Witness Form

This form must be emailed to the Committee Manager for the Committee hearing the bill. For bill hearings scheduled on or before February 11th by 10:00 am two (2) business days in advance of the scheduled bill hearing. For bill hearings beginning on February 14th by 10:00 am one (1) business day in advance of the scheduled bill hearing. Please include the date of the bill hearing and the bill number in the subject line.

Hearing Date: February 23, 2022
Bill Number: SB 688

Lead Proponent Name: Dr. Jennifer Dorr
Organization: Children's National Medical Center
E-mail Address:
Phone Number:

Panelist Name: Dr. Robert Herman
Organization:
E-mail Address:
Phone Number:

Panelist Name: Dr. Joseph Collins
Organization:
E-mail Address:
Phone Number:

Please also submit, along with this document:

- Any audio-visual presentation the sponsor wishes to show during his or her presentation.
- Any special requests for bill order. Please note, the Committee will do its best to accommodate requests.

Contact information for the Committee Managers:

Budget and Taxation: kim.landry@mlis.state.md.us
Education Health & Environmental Affairs: lamorea.stanton@mlis.state.md.us
Finance: tammy.kraft@mlis.state.md.us
Judicial Proceedings: sandra.popp@mlis.state.md.us

2022.2.22 APA Supports SB 688 - Prior Auth.pdf

Uploaded by: Kathya Orellana

Position: FAV

AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

February 23, 2022

Chair Delores G. Kelley
Vice-Chair Brian J. Feldman
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: SB 688 – Health Insurance – Utilization Review for Coverage of Prescription Drugs and Devices – Expedited Appeals

Dear Chair Kelley and Vice Chair Feldman,

On behalf of the American Psychiatric Association, a national medical specialty society representing more than 37,400 psychiatric physicians, as well as their patients and families, we respectfully ask for your support of SB 688. If passed, this bill would help clinicians ensure that their patients have timely access to medications by reducing the burden of prior authorization.

Prior authorization is a utilization management tool that requires doctors to obtain approval from an insurance plan or pharmacy benefit manager (PBM) before it will cover the costs of a specific medicine, medical device, or procedure. While prior authorization is promoted as a health care savings mechanism, this process likely contributes to the rising cost of healthcare by allowing insurers and PBMs to impose extensive paperwork requirements, multiple phone calls, and significant wait times for treatments and medications.

The result of prior authorization on patients may be life threatening and lead to higher costs. According to a 2021 survey by the American Medical Association, over 90% of doctors report that prior authorization has delayed patient access to care and negatively impacted patient outcomes. Four in five doctors reported that prior authorization can lead patients to abandon their recommended course of treatment. For individuals with psychiatric disorders, including those with serious mental illness or substance use disorders, gaps in treatment due to prior authorization denials can lead to relapse, along with increased health care costs and devastating effects for individuals and their families.

The pandemic has exacerbated the need for mental illness and substance use disorder services both in Maryland and nationwide. In just the last year, NAMI reports that our state lost 650 lives to suicide and 188,000 adult residents reported thoughts of suicide. In this time of crisis, we should eliminate barriers to treatment and do all that we can to support our overwhelmed healthcare workforce. SB 688 would ensure patients access to the medications they need and would alleviate some of the pandemic burnout clinicians are experiencing.

Increasingly, legislators across the country are recognizing how onerous prior authorization is on clinicians and that time spent on burdensome requirements would be better spent on direct patient care. Last year, legislators in Georgia, Illinois, Oregon, and Texas recognized the negative impact of prior authorization on patient access and passed their own prior authorization reform bills. As we enter the second year of this pandemic, we have seen proposals in Colorado, Indiana, Maine, New Jersey, and Washington to reign in insurance authority on patient access to care and mitigate a fraction of the stress that our healthcare workforce is experiencing.

Specifically, SB 688 would:

- eliminate prior authorization for generic medications that are not controlled substances.
- eliminate prior authorization for dosage changes of the same medication.
- eliminate prior authorization for generic and brand drugs after patients have been on these medication for six months without interruption.
- require insurers and PBMS to adhere to a 48-hour appeal process to ensure timely access to medications for patients.
- prohibit plans from denying medication on the grounds of therapeutic duplication if the patient has already been subject to review for the same dosage and it was previously approved.
- require denials and denial reviews be conducted by physicians in the same or similar specialty as the health care provider whose recommended treatment is under review.

Maryland patients deserve timely access to medications. Please support SB 688 and implement common sense changes to prior authorization. If you have any questions, please contact APA Director of State Government Relations, Erin Philp at ephilp@psych.org.

Sincerely,

Saul Levin, M.D., M.P.A., FRCP-E, FRCPsych
CEO and Medical Director
American Psychiatric Association

PA - Testimony SB 688.pdf
Uploaded by: Steven Israel
Position: FAV

Washington Psychiatric Society

The Honorable Delores G. Kelley
Senate Finance Committee
3 East – Miller Senate Office Building
Annapolis, MD 21401

RE: Support – SB 688: Health Insurance - Utilization Review for Coverage of Prescription Drugs and Devices - Expedited Appeals

Dear Chairman Kelly and Honorable Members of the Committee:

As President of the Washington Psychiatric Society, which represents psychiatrists in Montgomery and Prince George's County, and as a psychiatrist who has practiced for over 30 years in Rockville, I am eager to express my support for SB 688. Long overdue, it would impose needed controls on the excessive, harmful elements of prior authorization as it operates today. Billed as a cost-saving and perhaps disingenuously as a patient-safety measure, prior authorization is out-of-control. It was implemented like a scorched-earth military campaign, apparently with little oversight or anticipation of the collateral damage.

Consider some of the treatment-disruptive practices associated with prior authorization:

- Coverage being denied by pharmacists based on criteria that do not accurately apply to the clinical situation who lack understanding of appropriate practice as it applies to the individual case.
- Appeal processes that take too long to be of help in the immediate clinical situation.
- Prior authorization required for generic medication.
- Prior authorization required when medication doses are changed.
- Prior authorization being required repeatedly for patients with chronic conditions who have taken the same medication for years.

Prior authorization has transformed the process of writing a prescription into what can be 15-to-30-minute process—sometimes much longer. Even when a pharmacy benefit manager approves a medication, a prior authorization requirement causes a delay in treatment The sheer volume creates backlogs that can make more extended interruptions inevitable. When, as if often the case, coverage is denied for the wrong reason, or patients are forced to try medications that are unlikely to be of benefit, delays can last several weeks.

There is a human cost: in psychiatry patients get more depressed, more psychotic, more suicidal, more homicidal. Family conflicts intensify. People miss work. Missing doses of some medications (SSRI's, buprenorphine) cause withdrawal symptoms. Others, like lamotrigine, can't be restarted at the effective dose, but have to be slowly increased, delaying the resumption of the therapeutic effect. I've had patients with psychotic disorders who've missed doses, become more symptomatic lose their insight into the need for treatment, and stop medications altogether. In one case, this led to an inpatient hospitalization. Indeed, in a recent AMA survey 82% of physicians report that prior authorization can lead to treatment abandonment. 34 % of physician reported that prior authorization has led to a serious adverse event for their patient.

The damage occurs on an even broader level. This massive addition to our already onerous paperwork burden speeds the process of physician burnout. It's easy to become detached and demoralized when one feels their best efforts are thwarted and there's no end to the work to be done. A day has only 24 hours. Prior authorization steals time when we should be returning phone calls, meeting with family members, coordinating care with colleagues, or even thinking deeply about a difficult case. It's hard to quantify the harm that caused in this way, but I can't imagine that it does not significantly degrade the quality of care.

SB 688 strives to place controls on the most problematic aspects of prior authorization practices. To start, they tighten the time frame for decisions and appeal. Further, it requires that the decision to deny a medication be made by a physician who practices in the same specialty as the prescriber, or one whose specialty works with the illness the medication is intended to treat. Really, only a physician has the understanding to correctly apply the criteria to the individual patient. And it's only a physician who knows what standard practice would dictate. There's a reason why insurance companies must conduct doctor to doctor reviews before rendering an adverse decision in critical clinical situations, like whether patient can be admitted to or continue inpatient hospitalization. Decisions about medication can be just as critical and have consequences that are just as serious. The bill also would reduce unnecessary time-consuming busy work by ending prior authorization requirements for non-controlled generic medication, dose changes of the same medication, and medications that patients take chronically.

To conclude, as implemented today, prior authorization practices are excessive, place an overwhelming burden on providers, and cause delays in treatment that cause harm to patients. It is hoped that Committee will share these concerns and support SB 688.

Thank you for your consideration.

Sincerely yours,

Steven B. Israel, MD
President, Washington Psychiatric Society

SB 688 - Support - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FAV

February 20, 2022

The Honorable Delores G. Kelley
Senate Finance Committee
3 East – Miller Senate Office Building
Annapolis, MD 21401

RE: Support – Senate Bill 688: Health Insurance - Utilization Review for Coverage of Prescription Drugs and Devices - Expedited Appeals

Dear Chairman Kelley and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS strongly support Senate Bill 688: Health Insurance - Utilization Review for Coverage of Prescription Drugs and Devices - Expedited Appeals (SB 688) as this is a priority piece of legislation for both these physician groups.

When a physician or other clinician prescribes medication or treatment for a patient, the patient's insurance company or pharmaceutical benefits manager (PBM) requires an explanation as to why it is necessary before approving coverage. This utilization management tool of the insurance carriers and PBMs is called "prior authorization." While prior authorization is promoted as a health care savings mechanism, this process simply creates extensive paperwork requirements, multiple phone calls, and significant wait times for both prescribers and their patients. In the end, prior authorization often leads to patients experiencing arbitrary limits on medications and untimely and/or incomplete treatment of their underlying conditions. A staggering ninety percent (90%) of physicians report that prior authorization significantly negatively impacts patient outcomes.

Remarkably, no clear evidence exists that prior authorization improves patient care quality or saves money. Instead, it often results in unnecessary delays in receiving life-sustaining medications or other treatments and leads to physicians spending more time on paperwork and less time treating their patients. For individuals with psychiatric disorders, including those with serious mental illness or substance use disorders, gaps in treatment due to pre-

authorization denials can lead to relapse, with increased health care costs and devastating effects for individuals and their families

As a start to fixing prior authorization, policymakers and other stakeholders should consider how the volume of prior authorization impacts patients, physicians, and the health care system. While this utilization management tool may reduce the amount health insurers are paying for care in the short term, delaying or denying medically necessary care is not an appropriate or effective long-term solution to reducing costs. Instead, prior authorization, if used at all, must be used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians, and other providers. SB 688 takes just that approach.

SB 688 seeks to accomplish the following:

- **Eliminate prior authorization for generic medications that are not controlled substances.** These medications are cheap and not addictive; therefore, prior authorization provides no benefit to costs or patient safety.

- **Eliminate prior authorization for dosage strength changes of the same medication**. Patients may often require a dosage adjustment, and prescribers should not be constricted by administrative barriers to use their professional judgment.

- **Eliminate prior authorization for generic and brand drugs after patients have been on the medication for six months without interruption.** Once a patient has demonstrated a stable adherence to their treatment plan, his or her prescriber should not be subjected to additional prior authorizations.

- **Require insurers and PBMS to adhere to a 48-hour appeal process to ensure timely access to medications for patients.** Too often, patients may suffer serious harm without access to their medication while they wait for insurers or PBMs to approve their medication coverage. For those medications still subject to review, it is imperative that insurers and PBMs provide a timely response to ensure continuity of care;

- **Prohibit plans from denying medication on the grounds of therapeutic duplication if the patient has already been subject to review for the same dosage and it was previously approved.** When a patient requires a certain dosage of medication that is not manufactured in that specific dosage, prescribers may write two corresponding prescriptions to create a unique dose for the patient. Patients are often denied coverage of this medication based on “therapeutic duplication” without recognizing the patient’s dosing needs.

- **Require denials and denial reviews to be conducted by physicians in the same profession or similar specialty as the health care provider whose recommended treatment is under review.** Insurers and PBMs have been empowered to practice medicine without a license to make coverage denials. Even when a physician is conducting utilization reviews, a psychiatrist may receive a denial from a cardiologist, who lacks the clinical expertise. This change would ensure that denial and denial reviews are overseen by an expert who is familiar with the treatment plan and type of patient under review.

Patients, especially those with mental health and substance use disorders, need timely access to medication. Please support SB 688, which makes common-sense changes to prior authorization. For all the reasons above, MPS and WPS ask the committee for a favorable report on SB 688.

If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee

OAG HEAU_INF_SB0688.pdf
Uploaded by: Patricia O'Connor
Position: INFO

BRIAN E. FROSH
Attorney General

ELIZABETH F. HARRIS
Chief Deputy Attorney General

CAROLYN QUATTROCKI
Deputy Attorney General

WILLIAM D. GRUHN
Chief
Consumer Protection Division

Writer's Direct Fax No.
(410) 576-6571

Writer's Direct Email:
poconnor@oag.state.md.us

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

Writer's Direct Dial No.
(410) 576-6515

February 22, 2022

To: The Honorable Delores G. Kelley
Chair, Finance Committee

From: The Office of the Attorney General's Health Education and Advocacy Unit

Re: Senate Bill 688 (Health Insurance - Utilization Review for Coverage of Prescription Drugs and Devices - Expedited Appeals): Information

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) understands from the sponsor's staff that the intent of this bill is to curtail the unjustifiably negative effects of utilization review by carriers who increasingly deny claims for prescription drugs and devices prescribed by providers. Utilization review is the process whereby carriers effectively make medical judgments about a provider's prescription, and substitute their judgment about what should be prescribed.

The HEAU supports the good intentions of this bill. We have some concerns about the proposed utilization review "appeal" processes that are proposed, which appear intended to be distinct from, but parallel to, the current requirements in Md. Code Ann., Ins. § 15-10A, 10B and 10D. For example, current Maryland law has two similar processes for patients to dispute carrier determinations, one (§ 15-10A) for carriers' denials that proposed or delivered health care services are not or were not *medically necessary* ("adverse decisions") and another (§15-10D) for carriers' determinations that result in the *contractual exclusion* of a health care service ("coverage decisions"). Challenges to "adverse decisions"- decisions based on utilization review- are "grievance decisions" and challenges to "coverage decisions" are "appeals."

This bill uses the term "appeal" to describe a challenge to a utilization review decision, which will create confusion and could inadvertently limit consumer rights. (e.g., page 2, lines 26 and 31; page 3, lines 2, 8, 19, etc.) It is also unclear how the "appeal"

process outlined in this bill can be "independent" and "distinct" from the processes outlined in 15-10-A and 15-10-D. We believe the processes are too interrelated to be distinct. (Page 3, lines 19-22).

We are also concerned about page 2, lines 31-34, which provides for an expedited appeal for an emergency case to be handled by the "entity subject to this section." Under current law, if the denial of coverage is an emergency and eligible for an expedited review, the consumer can bypass the carrier and seek the Commissioner's assistance and the Commissioner is required to render an opinion within 24 hours, not 48 hours as contemplated by this bill. *See* § 15-10A-03. We frequently assist consumers with emergency cases and believe the introduction of this provision could inadvertently undermine consumers' current emergency rights.

We respectfully ask the committee to seek the input of the Maryland Insurance Administration, the state agency charged with enforcing the current utilization review process, including private review agent criteria, about how to strengthen consumer protections regarding utilization review of carriers without inadvertently reducing or hindering consumer rights under existing law.

cc: Sponsor