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TO: Melony Griffith, Chair
Senate Finance Committee
FROM: Office of the Attorney General, Health Education and Advocacy Unit
RE: SB0308 – Health Insurance – Utilization Review – Revisions: **Support**

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports the goal of curtailing the unjustifiably negative effects of utilization review by carriers that increasingly deny claims for drugs and medical services prescribed by providers. Utilization review is the process whereby carriers effectively make medical judgments about a provider's treatment recommendation and substitute their judgment about that treatment, using criteria that are often not publicly shared in advance with consumers or providers. The HEAU also supports eliminating unnecessary preauthorization requirements and streamlining the preauthorization process when appropriately utilized. The changes this bill proposes should help eliminate dangerous delays in care, reduce inappropriate denials of medically necessary care, and reduce administrative costs.

The HEAU assists consumers in mediating and filing a grievance or appeal of carrier adverse decisions (denials based on medical necessity, appropriates or efficiency) or coverage decisions (denials other non-coverage decisions). In fiscal year 2022, the HEAU closed nearly 600 appeals and grievances cases, mediating 436 of those cases. Of the 436 cases, 26% were adverse decision cases, 56% were coverage decision cases, and 18% were eligibility cases. The HEAU mediation process resulted in 65% of the medical necessity cases and 56% of the coverage decision cases being overturned or modified.

In one case, a 42-year-old woman diagnosed with psoriatic arthritis had been stable on Remicade infusions every 6 weeks with a dosage of 7 mg/kg since 2017. In July 2021, the carrier abruptly denied the Remicade claim, declaring "you will be held to FDA dosing guidelines not to exceed [6 mg/kg every 8 weeks]." In her internal appeal

letter, the rheumatologist said "I have been made aware that the new policy at [the carrier] is to automatically deny any medication for a patient that is a higher dose or more frequent schedule than what the FDA product insert guide lists; even if it is a proven dose and schedule that has had significant benefit for a particular patient. This policy will jeopardize my patient's treatments and cause disease relapse, unnecessary pain, loss of income from not being able to work and irreversible damage to her joints." With the HEAU's intervention, the denial was overturned, and the prior dosage and frequency resumed. Several other patients filed complaints about the same carrier, which was denying medication claims notwithstanding each patient's established need for medically necessary treatments tailored to their disease progression and symptoms. The HEAU also obtained reversals of those denials.

In another case, a patient and her surgeon wanted to use a transoral approach to thyroidectomy, in which the thyroid is removed via the mouth to avoid the scarring of the neck that otherwise results from a traditional approach. The patient suffered from multinodal thyroid disease and enlarged goiter. The carrier denied the pre-authorization request. The day before the surgery, the HEAU received the complaint. The HEAU immediately filed an expedited appeal. The transoral thyroidectomy was then authorized in time for the surgery to proceed on schedule.

Additional data and case examples can be found in the HEAU's FY 2022 Annual Report to the General Assembly on the health insurance carrier appeals and grievances process. That report highlights the fact that HEAU's success rate for consumers is not unusual; carriers routinely deny claims that are usually overturned on appeal. In its Annual Report, the HEAU is also required to report on MIA's appeals and grievances data, which reflects that 72% of carrier grievance decisions in FY 2022 were reversed or overturned once the MIA investigated the denial. The same report reveals that while carriers overturned or modified 54% of their original adverse decisions during the internal grievance process in FY 2022, only 11% of consumers actually challenged the denial.

This bill attempts to address some of the concerns reflected in the data, which the HEAU fully supports. But, the HEAU does have some technical concerns about the bill and other recommendations, including, but not limited to:

1. The HEAU has some concerns about the language on page 7 lines 3-4, which appears to limit the notice requirements to adverse decisions, excluding coverage decisions in 10D. The proposed language is unnecessary because the provisions of 10A and 10B are required without the addition. If the proponents prefer the added language, we recommend including coverage decisions (10D), to avoid ambiguity the absence could create.

2. The HEAU supports elimination of prior authorizations for dosage changes of previously authorized prescription drugs within FDA limits but believes opioids should be carved out because the ongoing opioid epidemic continues to pose a threat to Marylanders. The FDA often approves drugs in wide ranges proposed by manufactures to cover rarer cases that are not mainstream, and assuming the administration of such doses will be confined to the worst cases. However, in the case of opioids, prior authorization requirements have acted as a check against overreaching. In a December 2019 National Drug Threat Assessment, the DEA noted Controlled Prescription Drugs were responsible for the most drug-involved overdose deaths and second most commonly abused substance in the United States. In the case of opioids, the goals of eliminating delays in care, reducing inappropriate denials of medically necessary care, and reducing administrative costs, are outweighed by the goals of preventing abuse, accidental over-dosing, and death.

3. The HEAU recommends requiring 60 days' notice of the introduction of a new prior authorization requirement because such a change amounts to a material plan modification. (Page 8, line 12)

4. Under current 15-10A-06 (page 15, lines 21-30), carriers report the number of adverse decisions to the Commissioner quarterly, but do not report the number of clean claims processed by the carrier. In our annual reports, the HEAU has long advocated for inclusion of the number of enrollees and clean claims in carrier quarterly reports because an analysis of the number of adverse decisions cannot be performed effectively without comparing that number to total enrollee and number of claims processed.

5. The HEAU supports requiring the offer of peer-to-peer (private review agent and provider) discussion when issuing an adverse decision but suggests removing the phrase "*medical necessity"* on page 20 in line 3 because adverse decisions are denials based on medical necessity, appropriateness or efficiency, and use of the term medical necessity alone could be misconstrued to be limiting.

We support this well-intentioned bill and look forward to working with all stakeholders to strengthen consumer protections regarding utilization review without inadvertently reducing or hindering consumer rights under existing law.