TO: The Honorable Melony Griffith, Chair

Members, Senate Finance Committee

The Honorable Katherine Klausmeier

FROM: Erinn Maury, MD
Rheumatologist, Owner of Mid-Atlantic Rheumatology in Millersville, MD phone: 410-787-9400

DATE: February 15, 2023f

RE: SUPPORT – Senate Bill 308 – Health Insurance – Utilization Review – Revision

On behalf of my patients and myself, I am writing in support of SB308 to improve the prior authorization process which will improve timely appropriate care to patients, allow my staff to provide other services such as chronic care management. Chronic care management can reduce costs to the health care system as a whole by keeping patients out of the ER, urgent care, and prevent the need for hospitalizations.

This example is of a patient who has insurance that is under the control of the Maryland Insurance Administration, who was mismanaged and ended up with serious complications because of the problems with the current prior authorization process not following clinical guidelines and evidence-based medicine.

My patient is a woman in her late 50s, working full time with a commercial insurance plan. She has had rheumatoid arthritis for about 7 years which has been somewhat difficult to control at times. She had recurrent denials for Orencia for management of rheumatoid arthritis even though I had clinical evidence indicating she would benefit from being on this drug rather than going back on yet another tumor necrosis factor inhibitor (TNF inhibitor) of which she had failed at least 2 in the past.

I provided journal articles showing the science behind why she would benefit from being on Orencia. Peer-reviewed scientific articles indicate that those who have 2 positive antibodies for rheumatoid arthritis are more likely to respond positively to Orencia than respond to TNF inhibitors. Because of delaying care, she had to be on prednisone much longer by months than would have been necessary. Instead, they forced my hand, and I ended up having to put her on a third TNF inhibitor, Remicade.

As anticipated, she did not respond all that well to Remicade. She then developed a rash which we were uncertain of its origin since it did not seem to be exactly correlated with when she had her Remicade and she had had rashes in the past. The rash became severe and she had to discontinue Remicade after the third dose. She had to go on even higher doses of steroids than she already was because the Remicade was not working for her. He had to go to the dermatologist where she was seen a few times and was finally biopsied. It turned out to be a drug eruption, likely secondary to Remicade. She had to stay on higher doses of steroids as it took quite a long time for this rash to completely resolve. She was covered head to toe, and it was extremely itchy for several months.

After that, I once again tried getting Orencia approved, however, her insurance company then requested that she try yet another tumor necrosis factor inhibitor after failing 3, 1 of which caused a serious rash

requiring high-dose steroids. You may be aware that high-dose steroids for a long period of time increases the risk of osteoporosis, diabetes, obesity, heart disease, adrenal insufficiency, and other problems. The side effects of prednisone at a high dose for a long period of time are generally not reversible. Although some people will no longer be diabetic once they stop steroids, other people remain diabetic.

She was on more steroids continuously for a year than she had to be. Over those 12 months, I tried 3 times to get Orencia approved. It wasn't until the 3rd try, writing a scathing appeal letter in support of putting the patient on Orencia and using the state Attorney General's office to assist in the appeal, the pharmacy benefit manager/insurance company finally relented and approved Orencia. Within a month of starting on Orencia, the patient's rheumatoid arthritis significantly improved, and I was able to reduce her dose of steroids.

Unfortunately, the patient developed osteoporosis during that time despite preventive medication and I started her appropriately on more powerful medication for management of osteoporosis. And even more unfortunately the patient now has thoracic spine fractures for which she needed to undergo 2 spine surgeries in the last month. I highly doubt that this patient would have incurred spinal fractures had I been allowed to manage her appropriately given my knowledge of rheumatology, staying up to date on the guidelines and using evidence-based medicine for her management. This patient is only in her late 50s. She works hard. She and her husband do not have a lot of money. He had to go out on disability due to his own medical problems. And now she is looking at having to go out on disability due to her own medical issues.

If the insurer had only followed clinical guidelines for management of rheumatoid arthritis as put out by the American College of rheumatology, or even pain attention to the peer-reviewed scientific evidence I provided showing that this patient would likely benefit from being on a different drug, I know that she would have avoided the terrible time with a whole-body drug rash, months and months of high-dose steroids at ate away her bones, and now the spinal fractures and spine surgeries that she has had to undergo.

This bill requires that ensures and pharmacy benefit managers follow clinical guidelines that are peer-reviewed and use evidence-based science and are formed by specialty societies such as the American College of rheumatology. In practice, rheumatologists use these guidelines, follow these guidelines, read new guidelines when they come out and our patients benefit from us following these guidelines. I only want the insurance carriers and pharmacy benefit managers to follow the same high standards that we follow in the practice of medicine.

Additional reasons to support SB308:

Generic drugs should be exempt from utilization review.

Here are real life examples I have seen multiple times in my practice of misapplication of the utilization review process:

1. Requests for prior authorization for a generic drug that costs $4.00 out of pocket at Wal-Mart.

2. Requests for prior authorization for a generic drug that costs less than $10.00 out of pocket at Wal-Mart
3. Request for prior authorization for a prednisone taper because the insurance company said that prednisone is considered a “drug for transplanted organs”. This is true, but prednisone is prescribed exceedingly more commonly to kids and adults for poison ivy, asthma, and allergic reactions, bronchitis, emphysema flare up etc. It also costs less than $5.00 out of pocket. If someone with severe asthma can’t get their prescription of prednisone filled right away because it’s being held up by a prior authorization, they risk ending up in the ER or hospitalized; this is much more expensive to the health care system (and the patient) than a $5.00 prescription.
4. Request for prior authorization for a generic antibiotic. Generic antibiotics are cheap. Generic antibiotic dispensing should never be delayed by utilization review since infections can progress and lead to hospitalization, ER visits, or death and cost the health care system more money.
5. In rheumatology, we have prior authorization requests for our basic generic drugs which are generally less than $100 out of pocket. We’ve been using these drugs to treat autoimmune diseases for at least 30 years. I have heard that the insurers have said that they request to prior authorization because they want to make sure we’re using the drug properly. This is a ludicrous reason. I have passed my boards for rheumatology twice and twice for internal medicine in the last 16 years. I also have 4 years of medical school, 3 years of internal medicine residency, 2 years of rheumatology fellowship, and 16 years of experience managing rheumatology patients. If I am not using these drugs properly by now, there is no way I would have passed my boards, and way I would still be in practice.

SB308 requires that there is making decisions on behalf of the insurance company, pharmacy benefit manager or in a peer-to-peer review be of the same specialty either board eligible or board-certified and have knowledge and experience in treating the conditions being reviewed. This should be the standard of care.

I have had to do peer-to-peer reviews as a second appeal after 2 denials for drug. I am a rheumatologist. Once, the "peer" they gave me was a pediatrician. While she was a physician, she was not my peer since she was not a rheumatologist. I made a statement as such to the physician on the other end of the phone. She, initially, was somewhat offended. However, after I explained that I was not her peer either. As an adult rheumatologist, I would never presume to make decisions regarding pediatric care. I have only had 6 weeks of training in pediatrics which was in medical school which was many years ago. I am not board-certified in pediatrics. In fact, I would think it malpractice or I to practice pediatrics unless in an extreme emergency where there were no other options. With my "peer" being a pediatrician, I would hope she would feel it to be inappropriate for her to make decisions on adult rheumatology patients. Our patients require the use of powerful immunosuppressive drugs and some chemotherapy drugs which require intensive monitoring. Pediatricians do not have training in these drugs except possibly during a pharmacology class in medical school.

SB308 also addresses timelines and improves transparency for the prior authorization process. I recently had a 24-year-old woman wait 2 months for a prior authorization to be addressed by the

insurer. Two months after we sent in the prior authorization, I get a phone call from a physician asking if I done the TB test which needs to be done prior to starting on the drugs that we use in rheumatology. I pointed out to the physician with whom I was speaking that on page 6 of the initial prior authorization we have sent in 2 months prior he would find the negative TB test which he was requesting. I do not understand how it took them 2 months to review the prior authorization for a basic rheumatology drug and they could not even read the 6 pages that we sent them from the initial prior authorization. This poor woman ended up quitting her job in the meantime because she could not keep up at work because of the severity of her psoriatic arthritis. She has since had to drop out of the workforce due to the delay in care and worsening of her arthritis. She hopes to get back into the work force at some point. This is an intelligent, hardworking, college educate, young woman who was aspiring to get a master's degree. That is now all on hold.

I appreciate your time and consideration in reviewing the merits of this bill. My goal is to protect patient's wellbeing, improve access to appropriate health care by following evidence-based medicine, common sense, and providing better services to my patients such as chronic care management. The revisions in this bill will help physicians and patients and will reduce overall costs to the health care system.

Sincerely

Erinn Maury, MD
Rheumatologist