TO: The Honorable Melony Griffith, Chair
Members, Senate Finance Committee
The Honorable Katherine Klausmeier

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RE: **SUPPORT** – Senate Bill 308 – *Health Insurance – Utilization Review – Revisions*

On behalf of the Maryland State Medical Society, the Maryland Chapter of the American College of Emergency Physicians, the Maryland Academy of Family Physicians, the Maryland Society of Eye Physicians and Surgeons, the Maryland Section of the American College of Obstetricians and Gynecologists, the Mid-Atlantic Association of Community Health Centers, and the Maryland Clinical Social Work Coalition, we submit this letter of **support** for Senate Bill 308.

Senate Bill 308 makes changes to the utilization review policies used by health insurance carriers to determine when a requested health care service is medically necessary. Too often, these policies are negatively affecting patients by either denying or delaying necessary care. In 2021, the American Medical Association conducted a survey on the impact that prior authorizations have on patients and found that 93% (more than 9 out of 10) of physicians reported delays in access to necessary care and 82% (more than 8 out of 10) of physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials.

The 2021 Report on the Health Care Appeals and Grievances Law (released December 1, 2022) reported that health insurance carriers rendered 81,143 adverse decisions (e.g., denials of health care services) in 2021 compared to 78,134 in 2018, representing an increase over the 4-year period. Even more troubling is the high rate of reversals by the Maryland Insurance Administration (MIA) when complaints are filed. In 2022, MIA modified or reversed the carrier's decision (or the carrier reversed its own decision during the course of investigation) 72.4% of the time, up from 70.5% in 2021. This means that in more than 7 out of 10 cases, the MIA ruled that the carrier was wrong, and that the patient should have received the health care service.

Utilization review policies, such as prior authorization, are also resulting in negative outcomes for providers. Two out of five physicians (40%) have staff dedicated to working on prior authorization requests. Physicians have also reported that their staff spends almost two business days each week completing prior

authorization requests. The time and money spent on completing prior authorization requests would be better used on clinical care.

Therefore, Senate Bill 308 seeks to address issues with prior authorization and utilization review management techniques to ensure that patients receive the care needed and providers are not overly burdened. First, Senate Bill 308 reduces the volume of prior authorization requests by:

- Allowing a patient to stay on a prescription drug without another prior authorization if the insurer previously approved the drug and the patient continues to be successfully treated by the drug.
- Exempting prescription drugs from requiring a prior authorization for dosage changes provided that the change is consistent with federal FDA labeled dosages.
- Removing the need to obtain a prior authorization for generic drugs.
- Eliminating the need for the patient to obtain more than one prior authorization for the same medication during the same treatment when the treatment is divided into two or more prescriptions because of differing formulations of the drug.

Senate Bill 308 makes changes to ensure greater transparency and accountability in how insurers determine whether a health care service is medically necessary by:

- Requiring that the criteria used in determining whether care is medically necessary is evidence-based and peer reviewed and that it is developed by organizations that work directly with health care providers or by a professional medical specialty society.
- Requiring that the physician making or involved in making the denial is knowledgeable of and experienced in the diagnosis and the treatment under review.
- Mandating that, prior to making a denial, the insurance carrier (i.e., physician responsible for determining denials) notifies the insured's physician or health care practitioner of the potential denial and makes him or herself available to discuss the basis for the denial and the medical necessity of the health care service.
- Requiring that the physician (or dentist) who is responsible for determining denials possess a current and valid Maryland license to practice medicine (or dentistry).
- Requiring that, if requesting additional information, the insurer provide the criteria and standards to support the need for the additional information.
- Altering response timeframes to account for the fact that patients need health care services 24/7.

Lastly, Senate Bill 308 seeks to improve the utilization review process by studying two major areas by:

- Standardizing electronic systems across all carriers (rather than each carrier having their own system) with the same data points and using a single point of entry, such as CRISP, to minimize the length of time required to submit and respond to prior authorization requests.
- The feasibility of implementing a "gold card" standard in Maryland, which would exempt health care practitioners who meet certain standards from prior authorization requirements.

With these changes, we believe that patients will be able to access needed health care services in a timely manner and will improve the accountability and understanding of current processes used. We urge a favorable vote.