MOH Support SB 791 Senate Finance 2024.pdf
Uploaded by: Allison Rollins
Position: FAV

Senator Pam Beidle, Chair
Senator Kathy Klausmeier, Vice-Chair
Senate Finance Committee
Miller Senate Office Building
11 Bladen St, Annapolis MD, 21401

MARYLAND ONCOLOGY HEMATOLOGY

February 21, 2024

Support SB 791: Health Insurance – Utilization Review – Revisions

Honorable Chair, Vice Chair, and Members of the Senate Committee,

Thank you for the opportunity to convey our Support for **SB 791: Health Insurance – Utilization Review – Revisions** on behalf of Maryland Oncology Hematology (MOH). Passage of this bill as introduced would make important updates to Maryland's prior authorization statutes that will have a meaningful impact on timely access to appropriate care for the critically ill patients that we treat.

At Maryland Oncology Hematology (MOH), we offer quality cancer care that provides every advantage to help control and cure the disease. Our team of 52 board-certified physicians and numerous advanced practitioners are dedicated to the evaluation and treatment of all types of cancers and blood disorders. Our providers are backed by a team of oncology certified nurses, laboratory technologists, and support staff, with one goal in mind, to provide personal care and support so our patients can focus on healing. With 15 locations across Maryland, we provide convenient and high-quality cancer care to over 77,000 cancer patients a year.

Utilization management processes like prior authorization were originally intended to be a check and balance for uncommon or high-cost procedures; however, it has now become a catchall for restricting access to care. Over the last few years, prior authorization requirements for common cancer treatments and oral oncolytic medications have significantly increased, leading to delays in needed care, interference with the physician-patient relationship, increases in overall health care costs as patients try and fail multiple costly treatment options before qualifying for the most appropriate drug, and most importantly, adverse outcomes for patients.

Without guardrails to protect the patient, these protocols would take clinical decision making out of the physician's hands and give it directly to the insurance company. Those at the health plan reviewing the prior authorization requests have no direct knowledge of the patient, insufficient training in the most up to date clinical evidence, and/or lack specialized expertise in cancer care.

With that in mind**, we urge the Senate Committee the pass this legislation with the following provisions preserved** so that patient's intended treatment protocols remain intact:

- **Prohibiting carriers from issuing a denial of care when a patient requests a renewal for a previously approved drug when they have been successfully treated on that drug in the past**. Switching patients from one drug to another in its class can cause patients to lose efficacy in their treatment regimens. Additionally, it has been cited to increase overall costs of care as the loss of efficacy leads to further physician office visits, potential increased dosages or instances of treatment, and hospitalizations.[1]
- **Requiring 90 days of continuity of care in authorized prescription drug coverage** as the patient transitions from one state health plan to the next. This will allow physicians to work with their patient's health plan to adapt treatment protocols as needed, if needed, in a way that minimizes harm to the patient.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7021884/

- **Mandating that health care provider requested "peer to peer" reviews must occur between clinicians of the same specialty.** Oncologists treat patients with diverse diseases expressing highly complex presentations. It is critical that peer-to-peer reviews in oncology be performed with clinicians who have background knowledge of malignancies.
- **Deeming carrier approval of prior authorization requests if unacknowledged within a certain timeframe.** Cancer patients' outcomes are highly dependent on the timeliness of access to care. By placing definitive guardrails around how long a health plan may deliberate on prior authorization, care delays can be diminished.
- **Studying the possible elimination of prior authorization through "Gold Carding" programs and "Value Based Care" arrangements**. The process of applying for prior authorization is a tremendous administrative burden on physician practices and causes an overwhelming care delay for patients. We support any endeavor to find a thoughtful, evidence-based approach to reduce this delay and burden.

Since we are treating so many individuals in our communities, our practice has a full team dedicated to processing prior authorization requests to ensure that our patients receive the most appropriate care. We accept every health plan offered in the state, offer a full range of charitable care options, and work with every patient to help meet their needs. The improvements to utilization management processes in state-based health plans that this bill has put forward will have a marked impact on our team's ability to process these administrative requests in a timely manner. It will lead to more improved outcomes for the 1 in 5 of our patients who are on state-based health plans by offering them reduced care delays, higher quality clinical supports, and more continuity in their access to medications.

This bill could be a game changer for the thousands of Maryland patients who rely on us every year for quality cancer care. If you have any further questions regarding the impact of prior authorization on cancer patients, please do not hesitate to reach out. We welcome the opportunity to be a further resource for you. Thank you for your time and we hope that you will consider joining us in our support for this measure.

Sincerely,

George Sotos, MD
Practice President
Maryland Oncology Hematology

SB 791_Prior Auth_Support.pdf
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Position: FAV

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

February 21, 2024

The Honorable Pamela Beidle
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 791 – Support

Dear Chair Beidle and Members of the Committee:

Kaiser Permanente is pleased to support SB 791, "Health Insurance - Utilization Review - Revisions."

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for over 825,000 members. In Maryland, we deliver care to approximately 475,000 members.

The carriers and provider community worked hard with all stakeholders to come to consensus on this legislation. The bill's sponsor convened a number of meetings throughout the summer and fall, and all stakeholders had a fair opportunity to participate in the process. We'd also like to thank MedChi for their hard work in building consensus. This is a fair compromise that we hope provides a better experience for patients and physicians while still providing health plans with appropriate tools to manage costs. To that end, we urge a favorable report.

Thank you for the opportunity to comment. Please feel free to contact me at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

Allison Taylor

Allison Taylor
Director of Government Relations
Kaiser Permanente

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[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

2024 Legislation (SB 791- HI - Utilization Review

Uploaded by: Ben Steffen

Position: FAV

MARYLAND Health Care Commission

Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

2024 SESSION
POSITION PAPER

BILL NO: **SB 791**

COMMITTEE: **Senate Finance Committee**

POSITION: **Support**

TITLE: **Health Insurance - Utilization Review - Revisions**

BILL ANALYSIS

SB 791 - Health Insurance - Utilization Review – Revisions if passed alters and establishes requirements and prohibitions related to health insurance utilization review; alters requirements related to internal grievance procedures and adverse decision procedures; alters certain reporting requirements on payors relating to adverse decisions; and establishes requirements on payors and health care providers relating to the provision of patient benefit information. The bill requires payors to establish and maintain an online process that links directly to all e-prescribing systems and electronic health record systems using certain national standards;[1] can accept and approve electronic prior authorization requests; and links to real-time patient out-of-pocket costs, including copayment, deductible, and coinsurance costs and more affordable medication alternatives. The Maryland Health Care Commission (MHCC) and Maryland Insurance Administration (MIA) are required to study the development of standards for the implementation of payor programs for prior authorization, including programs that have been implemented or are being considered in other states. A report on study findings and recommendations is due on December 1, 2024, to the General Assembly. The MHCC and MIA must establish a workgroup to assess progress toward implementing the law and review issues or recommendations from other states. A report on findings and recommendations from the workgroup is due on December 1, 2025, to the General Assembly.

POSITION AND RATIONALE

The MHCC supports the aims of SB 791 in reshaping prior authorizations processes for medical services and pharmaceuticals. On January 17, 2024, the Centers for Medicare &

[1] The National Council for Prescriptions Drug Programs (NCPDP) SCRIPT Standard and the NCPDP Real time Benefit Standard.

Medicaid Services (CMS) released the Interoperability and Prior Authorization Final Rule.[2] The Final Rule builds on initiatives by CMS and the Office of the National Coordinator for Health Information Technology to advance data sharing and interoperability of electronic health information to improve care continuity and patient access to information, and prevent information blocking.[3] Electronic prior authorizations help eliminate paper-based forms and manual submissions to accelerate review and decision-making so patients receive timely access to necessary treatments and medications.[4] Efforts to integrate technology and standardize electronic prior authorization processes support real-time status updates and goals of reducing administrative burden on providers.[5]

Electronic preauthorization emerged to streamline communications between providers and payors regarding patient coverage and eligibility and determinations of medical necessity.[6] In 2012, Maryland became one of the first states to enact legislation that required payors and pharmacy benefit managers (PBMs) to implement electronic preauthorization processes in a phased approach, which included a requirement to establish web-based portals.[7, 8] Chapters 534 and 535 (SB 540/HB 470) of the 2012 Laws of Maryland required MHCC to work with payors and PBMs to attain benchmarks for standardizing and automating the preauthorization process for medical services and pharmaceuticals.[9] The MHCC developed supporting regulations, which includes a process for a payor or PBM to be waived from attaining the benchmarks under certain circumstances.

At its core, electronic prior authorizations digitize and automate key steps to facilitate communication between providers and payors. The MHCC endorses the aims of SB 791

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[2] The CMS Final Rule full name is "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program." The CMS Final Rule is available at: www.cms.gov/files/document/cms-0057-f.pdf.

[3] Codified at 45 C.F.R. Part 171.

[4] RTI Health Solutions, *Evaluation Of The Fast Prior Authorization Technology Highway Demonstration*, October 2021. Available at: healthcare.rti.org/insights/evaluation-fast-prior-authorization-technology-highway-demonstration.

[5] National Library of Medicine, *Perceptions of prior authorization by use of electronic prior authorization software: A survey of providers in the United States*, October 2022. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC10332446/.

[6] Altarum Institute, "*Impacts of Prior Authorization on Health Care Costs and Quality*," November 2019. Available at: www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf.

[7] Enactment of the law was informed by an MHCC report based on recommendations from a multi-stakeholder workgroup, *Recommendations for Implementing Electronic Prior Authorizations,* December 2011.

[8] A web-based portal is a standalone system; also referred to as an "online preauthorization system."

[9] Md. Code Ann., Health-Gen. § 19-108.2.

that utilize national standards to streamline administrative processes, foster greater interoperability, reduce administrative burden, and speed up access to necessary treatments and medications. Improving electronic preauthorization supports improvements in care coordination and improves transparency between payors and providers conducting utilization review activities. The MHCC believes the legislation will support efforts to improve the delivery of quality care in a cost effective and timely manner.

The MHCC notes that the bill limit payors from issuing an adverse decision on a reauthorization for the same medication or request additional documentation from the prescriber for the reauthorization. To reassure payors, providers, consumers, and policymakers, the MHCC will monitor the impact of the bill, if enacted, using the Medical Care Data[10] to assess if this new regulatory framework continues to promote access to safe, effective, and affordable prescription medications.

For the stated reasons above, we ask for a favorable report on SB 791.

[10] The Medical Care Data Base, also called the All Payer Claims Data Bases contains medical and pharmacy utilization data for Medicare, Medicaid, the privately insured market

SB0791_MHAMD_FAV.pdf
Uploaded by: Dan Martin
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mhamd
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Senate Bill 791 Health Insurance - Utilization Review - Revisions
Finance Committee
February 21, 2024
Position: SUPPORT

Mental Health Association of Maryland (MHAMD) is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). We appreciate the opportunity to provide this testimony in support of Senate Bill 791.

SB 791 reforms utilization review[1] standards to improve patient access to needed health care. Among its many positive revisions, the bill specifies that private review agents (PRAs) must use utilization review criteria developed by a non-profit health care provider professional medical or clinical specialty society. If no specialty society exists, the bill requires that the utilization review criteria be consistent with standards generally recognized by health care providers practicing in the relevant specialty.

SB 791 also outlines a number of patient-centered requirements related to an insurance carrier's treatment determination processes that should help to limit carrier denials of needed health care (i.e. adverse decisions). The bill ensures that expedited reviews are based on the determination of the health care provider and not the carrier, sets a timeframe for authorizing additional visits/days for an existing course of treatment, requires that carrier denials explain why the request was not medically necessary and did not meet utilization review criteria, and provides that a request for care is deemed approved if a carrier fails to make a determination within a required timeframe.

The reforms in SB 791 are particularly important for those seeking mental health or substance use care. Too often, private health plans rely on medical necessity criteria that are not consistent with evidence-based care for mental health conditions. According to a recent national patient-experience survey conducted by NORC, nearly 70% of Marylanders reported that they had problems with their health insurance plan denying coverage for mental health or substance use care based on either the care not being medically necessary or the care being not covered or excluded.

And although carrier adverse decisions continue to increase (95,327 in 2022 compared to 81,143 in 2021),[2] and although upwards of 70% of challenged care denials are ultimately modified or reversed,[3] appealing adverse decisions is not a reasonable option for individuals experiencing a behavioral health crisis. Appealing decisions takes significant time and support, and currently less than one-half of one percent of adverse mental health or substance use disorder decisions are challenged.

SB 791 will limit inappropriate denials of care and help Marylanders get more timely treatment. For these reasons, MHAMD supports this bill and urges a favorable report.

[1] "Utilization review" is a process where a health insurance company, in advance of a health care service being rendered, reviews a health care provider's request for care to determine whether the service is medically necessary.
[2] https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2022-Report-on-the-Health-Care-Appeals-and-Grievance-Law-MSAR-6.pdf
[3] Id.

For more information, please contact Dan Martin at (410) 978-8865

AADA Support MD SB791.pdf
Uploaded by: Daniel Shattuck
Position: FAV

February 20, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Re: Support SB 791

Dear Chairperson Beidle,

On behalf of the more than 17,00 members of the American Academy of Dermatology Association, we write in support of SB 791. This legislation would be a critical step to ensure patients have access to their prescription medicines by placing guardrails on the use of prior authorization. Prior authorization is a cost containment tool used by health insurance plans requiring physicians and non-physician clinicians to obtain advance approval from a health plan before delivering a specific procedure, service, device, supply or medication.

While we understand the need to manage the unpredictable and growing costs of health care, prior authorization is often a hurdle to accessing medication and other procedures, such as Mohs micrographic surgery, phototherapy, and patch testing. As explained below, we urge you and members of the Senate Finance Committee to support SB 791.

Prior authorization has greatly impacted the ability of our patients to access their medications. According to a 2020 survey of Academy members, approximately one quarter of dermatology patients per day require prior authorization, and only half are successful. Of the 50% who do not access the medication prescribed by their dermatologist, 36% reported receiving a less effective medication and 27% either delayed or abandoned their treatment. Dermatology patients who seek biologics often wait more than two weeks to more than one month to obtain their medications as a result of prior authorization. Delays in accessing prescription medications can cause irreparable harm to patients in need of timely access to specific treatments.

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The choice of therapy should be between physicians and their patients where consideration of all factors— efficacy and safety of all treatment options, co-morbidities, and support system— are fully vetted and discussed. Dermatologists are uniquely positioned to make the most appropriate therapeutic decisions in collaboration with their patients due to their extensive medical education and training, which includes a minimum of 8 years of medical education (4 years of medical school, 1 year of internship, 3 years (minimum) of a dermatology residency), followed by annual continuing medical education requirements. Prior authorization replaces the medical judgement of the patient's physician with a third party, who lacks the complexity and full history of the patient's condition, into an inappropriate decision-making role.

Further, prior authorization poses significant administrative burdens on dermatology practices. The financial cost to practices averages $40,000 to either hire or redistribute staff to manage the prior authorization process, which can take up to an average 3.5 hours of work per day. According to dermatology practice administrators, the time spent on prior authorization equates to an average five to eight additional patients per day that could be scheduled.

We appreciate the opportunity to provide written comments on this important public health issue and urge your support for SB 791. As physicians, our number one priority is the health and welfare of our patients. The passage of this legislation will improve access to prescription medications that are in the best interest of the patient. For further information, please contact Lisa Albany, director of state policy for the America Academy of Dermatology Association, at LAlbany@aad.org or (202) 712-2615.

Sincerely,

Karry La Violette
Senior Vice President, Advocacy and Policy
American Academy of Dermatology Association

APTA MD Testimony 2024 - Support - Senate Bill 791

Uploaded by: Daniel Shattuck

Position: FAV

APTA Maryland

February 21, 2024

The Honorable Pam Beidle, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: Senate Bill 791– Health Insurance – Utilization Review – Revisions**- SUPPORT**

Dear Chair Beidle,

We represent over 1,800 members and our mission is to foster excellence in the profession of physical therapy by advocating, educating, and promoting best practices to improve the human experience of the diverse society we represent and serve.

APTAMD is part of a coalition to improve patient centered care through legislation titled: ***Health Insurance –Utilization Review - Revisions***

Health insurance carriers engage in a process known as "utilization review," which is a system where the carrier reviews a practitioner's request that a patient receive a certain health care service to determine if the service is medically necessary. The two most common types are "prior authorization," which is requesting approval in advance from the carrier and "stepped care," where the patient must try and fail on other medications (often less expensive) before "stepping up" to another medication.

Senate Bill 791 will improve the prior authorization process by adding transparency, aligning standards, and increasing accountability of the insurers.

The 2021 Report on the Health Care Appeals and Grievances Law (released December 1, 2022) reports that carriers rendered 81,143 adverse decisions (e.g., denials of health care services based on the carrier's decision that the health care service was not medically necessary rather than the judgment of the treating practitioner).

In 2022, the Maryland Insurance Administration (MIA) modified or reversed the carrier's decision (or the carrier reversed it during the course of investigation), 72.4% of the time on filed complaints, 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.

The 2021 American Medical Association conducted a survey on the impact that prior authorizations have on physicians and patients and found that:

- 93% of the time physicians reported delays in access to necessary care.
- 82% of the time physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials.
- 73% of the time physicians reported that criteria used by carriers for determining medical necessity is questionable - 30% of the time physicians reported that it is rarely or never evidence-based and 43% only sometimes evidence-based.

APTA Maryland Ph. 800.306.5596 Fax 877.622.0960 aptamd@aptamd.org

APTA Maryland
A Chapter of the American Physical Therapy Association

This legislation would reform prior authorization by:

- Require evidence-based, peer reviewed criteria as the standard of care developed by an organization that works directly with health care providers or a professional medical specialty society.
- Mandate that a physician which made or participated in the adverse decision notify the insured's physician or health care practitioner prior to making the adverse decision and be available to discuss the basis for the denial and the medical necessity of the health care service rather than deny care and then allow for a peer-to-peer meeting after the fact.
- Created a timeline for response by carriers for requests for services or extension of services within 1 working day AND approve requests automatically when a private review agent fails to respond to a request in the mandated amount of time.
- Study the feasibility of a "gold card" standard in Maryland, which would exempt health care practitioners who meet certain standards from prior authorization standards.

The Data –Ultimate Outcome of Physical Therapy Denied Claims

- *13.08% of filed physical therapy claims are denied*
- *66.14% of denied physical therapy claims are appealed*
- *52.34% of appealed physical therapy claim denials are overturned*

The American Physical Therapy Association (APTA) conducted a survey on administrative burden from Dec 2018-Jan 2019. APTA members report that medically necessary physical therapist services are delayed — ultimately impacting patients' clinical outcomes — because of the amount of time and resources they must spend on documentation and administrative tasks. The volume of these tasks also leads to dissatisfaction and burnout. APTA urges policymakers and third-party payers to advance policies that streamline documentation requirements, standardize prior authorization and payer coverage policies, and eliminate unnecessary regulations.

- 85.2% of providers agree or strongly agree that administrative burden contributes to burnout.
- 74% of respondents agreed or strongly agreed that prior authorization requirements negatively impact patients' clinical outcomes.
- 76% of facilities and private practice owners have added nonclinical staff to accommodate administrative burden.
- 65% of respondents say more than 30 minutes of staff time is spent preparing an appeal for one claim.

If you have any questions, please contact us at 800-306-5596 or aptamd@aptamd.org.

Sincerely,

Roy Film, DPT

Roy Film, DPT
Board Certified Orthopaedic Physical Therapist
Fellow, American Academy of Orthopaedic Manual Physical Therapists
President, APTA Maryland

MDS Support_SB791.pdf
Uploaded by: Daniel Shattuck
Position: FAV

Maryland Dermatologic Society

February 20, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Re: Support SB 791

Dear Chairperson Beidle,

On behalf of the nearly 150 members of the Maryland Dermatologic Society, we write in support of SB 791. This legislation would be a critical step to ensure patients have access to their prescription medicines by placing guardrails on the use of prior authorization. Prior authorization is a cost containment tool used by health insurance plans requiring physicians and non-physician clinicians to obtain advance approval from a health plan before delivering a specific procedure, service, device, supply or medication.

While we understand the need to manage the unpredictable and growing costs of health care, prior authorization is often a hurdle to accessing medication and other procedures, such as Mohs micrographic surgery, phototherapy, and patch testing. As explained below, we urge you and members of the Senate Finance Committee to support SB 791.

Prior authorization has greatly impacted the ability of our patients to access their medications. According to a 2020 survey of members of the American Academy of Dermatology, approximately one quarter of dermatology patients per day require prior authorization, and only half are successful. Of the 50% who do not access the medication prescribed by their dermatologist, 36% reported receiving a less effective medication and 27% either delayed or abandoned their treatment. Dermatology patients who seek biologics often wait more than two weeks to more than one month to obtain their medications as a result of prior authorization. Delays in accessing prescription medications can cause irreparable harm to patients in need of timely access to specific treatments.

February 20, 2024
Re: Support SB 791

The choice of therapy should be between physicians and their patients where consideration of all factors— efficacy and safety of all treatment options, co-morbidities, and support system—are fully vetted and discussed. Dermatologists are uniquely positioned to make the most appropriate therapeutic decisions in collaboration with their patients due to their extensive medical education and training, which includes a minimum of 8 years of medical education (4 years of medical school, 1 year of internship, 3 years (minimum) of a dermatology residency), followed by annual continuing medical education requirements. Prior authorization replaces the medical judgement of the patient's physician with a third party, who lacks the complexity and full history of the patient's condition, into an inappropriate decision-making role.

Further, prior authorization poses significant administrative burdens on dermatology practices. The financial cost to practices averages $40,000 to either hire or redistribute staff to manage the prior authorization process, which can take up to an average 3.5 hours of work per day. According to dermatology practice administrators, the time spent on prior authorization equates to an average five to eight additional patients per day that could be scheduled.

We appreciate the opportunity to provide written comments on this important public health issue and urge your support for SB 791. As physicians, our number one priority is the health and welfare of our patients. The passage of this legislation will improve access to prescription medications that are in the best interest of the patient. For further information, please contact Russ Kujan, executive director of the Maryland Dermatologic Society at rkujan@medchi.org or 410-539-0872.

Sincerely,

Rachel Schleichert, MD, FAAD
President
Maryland Dermatologic Society

SB0791_FAV_MedChi, MDAFP, MDAAP, MDCSCO, MDACOG, M

Uploaded by: Danna Kauffman

Position: FAV

TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Katherine Klausmeier

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Andrew G. Vetter
Christine Krone
410-244-7000

DATE: February 21, 2024

RE: **SUPPORT** – Senate Bill 791 – *Health Insurance – Utilization Review – Revisions*

On behalf of The Maryland State Medical Society, the Maryland Academy of Family Physicians, the Maryland/District of Columbia Society of Clinical Oncology, the Maryland Section of The American College of Obstetricians and Gynecologists, the Mid-Atlantic Association of Community Health Centers, and the Greater Washington Society for Clinical Social Work, we submit this letter of **support** for Senate Bill 791.

Senate Bill 791 is a modified reintroduction of Senate Bill 308 from the 2023 Session.[1] The bill is a result of a workgroup convened during the 2023 Interim, where almost a dozen meetings took place between physicians, health care practitioners, and payors along with their representatives and parties to reach agreement on the bill's provisions, prior to introduction. Therefore, Senate Bill 791 makes changes to the utilization review policies used by health insurance carriers to determine when a requested health care service is medically necessary to ensure that decisions are being made timely and are based on appropriate clinical and medical standards. Most importantly, Senate Bill 791 contains a provision that will allow a patient to remain on a medication when that medication was previously approved by the patient's insurance company and the patient has been well-maintained on that medication. Most often, this scenario affects patients with serious mental illness or other chronic conditions (i.e., autoimmune diseases, hypertension, diabetes) whose treatment plan requires the use of maintenance drugs.

Utilization review policies used by insurance carriers are negatively affecting patients, by either denying or delaying necessary care. A recent survey by the American Medical Association found that 93% (more than 9 out of 10) of physicians reported delays in access to necessary care and 82% (more than

[1] A similar bill was also introduced in the 2022 Session. 2022 Regular Session - Senate Bill 688 First Reader (maryland.gov)

8 out of 10) of physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials. Equally important is the data from the Maryland Insurance Administration's (MIA) 2022 Report on the Health Care Appeals and Grievances Law (released December 1, 2023) that shows the number of denials of care continues to increase year after year. In 2022, the number of denials reported from the insurance carriers to the MIA was 95,327 whereas in 2021 that number was 81,143. 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.

Senate Bill 791 achieves the following:

1. **<u>Reducing/Streamlining the Volume of Prior Authorization Requirements</u>**

    a. Prohibiting a carrier from issuing a denial of care when a patient requests a medication renewal if the insurer previously approved the drug, the patient has been successfully treated on the prescription drug, and the prescriber attests that the patient continues to need the drug.
    b. Exempting prescription drugs from requiring a prior authorization for dosage changes provided that the change is consistent with federal FDA labeled dosages and is not an opioid.
    *** Maryland law already prohibits prior authorization for a prescription drug when used for treatment of an opioid use disorder and that contains methadone, buprenorphine, or naltrexone.*
    c. Requiring a carrier to allow a patient who changes health insurance carriers to remain on the patient's medication for a period of the lesser of 90 days or the course of treatment during which time the new carrier can perform its own prior authorization review.
    d. Requiring a carrier to provide 60 days' notice rather than the current 30 days' notice when it implements a new prior authorization requirement.
    e. Requiring that a carrier, when approving a prior authorization request, to approve a course of treatment of a non-medication health care service for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation.

2. **<u>Increasing Transparency and Communication as Part of the Review Process</u>**

    a. Ensuring that the decision of when a case requires an expedited review after a denial is based on the determination of the health care provider and not the carrier (i.e., expedited reviews must be conducted within 24 hours).
    b. Requiring that any communication from the carrier where there is a denial of health care services states in detail the factual bases for the decision that explains the reasoning why the health care provider's request was not medically necessary and why it did not meet the criteria and standards used in conducting the review, which must be specifically referenced and not simply referred to "as part of the member's policy or plan document."
    c. Requiring carriers to have a dedicated call line or dedicated/monitored email address for denials so that health care providers can discuss the decision or schedule a time to discuss with the carrier, rather than having to go through the general customer call line.
    d. Requiring that if any additional information is needed to make the determination, the carrier must provide the specific information needed, including any lab or diagnostic test or other medical information, along with the criteria and standard used to support the need for the additional information.

e. Adding new reporting requirement within the annual report on utilization review by the MIA to determine how many patients requested a formulary or copay tier exception when changes have occurred to either.
f. In addition to satisfying other factors, eliminating "homegrown" criteria in favor of requiring carriers to utilize criteria and standards that are developed by nonprofit medical or clinical specialty societies or organizations that work directly with health care providers in the same specialty.
g. Mandating that a "peer to peer" must occur if requested by the health care provider (currently – it is discretionary).
h. Mandating that if the carrier does not meet the required times for making a determination, the request is deemed approved.

3. **Future Review Changes**

a. Studying whether to implement changes to the prior authorization requirements based on a health care provider's prior practice (otherwise known as the "gold card").
b. Reviewing whether to eliminate prior authorization requirements when a health care provider participates in a value-based arrangement.
c. Imposing a future requirement (2026) that carriers' electronic processes must integrate with all electronic health records to provide real time benefit information on a patient's coverage at no cost to the health care provider.

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.

MD_SB791_FAV_Inseparable Testimony_2024 02 21 - FI
Uploaded by: David Lloyd
Position: FAV

inseparable

409 7th St Northwest, Suite 305
Washington, D.C. 20004
February 21, 2024

Senate Finance Committee
Maryland General Assembly
3 East, Miller Senate Office Building
Annapolis, MD 21401

Via electronic submission

RE: SUPPORT FOR SB 791

Dear Chair Beidle, Vice-Chair Klausmeier, and Members of the Committee:

On behalf of Inseparable, I am testifying to urge your support of SB 791, which will improve access to lifesaving mental health and substance use disorder (MH/SUD) treatment. SB 791 will reduce inappropriate denials of care and help ensure that medical necessity determinations are consistent with accepted clinical standards of care.

Inseparable is a national nonprofit focused on closing the treatment gap for people with MH/SUDs, improving crisis response, and supporting prevention and early intervention. We are proud to support SB 791, which is an essential step to addressing Maryland's MH/SUD crisis. We are deeply appreciative of Vice-Chair Klausmeier and Delegate Cullison's leadership in bringing together stakeholders – including insurers – to put forward a strong proposal that will reduce barriers to MH/SUD treatment at a time of such overwhelming need.

We strongly support the following critical provisions in SB 791.

Protect Patients from Life-Threatening Denials of Needed Care

SB 791 includes essential, common-sense reforms that require insurers to conduct utilization review in a manner consistent with accepted clinical standards of care and using transparent, peer-reviewed nonprofit medical or clinical specialty criteria. More than 30 national organizations including The Kennedy Forum, Inseparable, National Alliance on Mental Illness, Mental Health America, the American Psychiatric Association, American Hospital Association, and the American Academy of Child and Adolescent Psychiatry have strongly endorsed such provisions.[1] These requirements are especially critical in increasing the quality of care by aligning providers and payers around transparent, peer-reviewed clinical criteria and guidelines. Maryland – like a number of other states – already requires that plans use The ASAM Criteria

[1] See relevant provisions contained in The Kennedy Forum's Jim Ramstad Model State Legislation to Advance Mental Health and Addiction Equity By Requiring Compliance with Generally Accepted Standards of Care, 2021. https://www.thekennedyforum.org/app/uploads/2021/05/Ramstad-Model-Legislation-May-2021.pdf.

from the American Society of Addiction Medicine's Criteria for determining the appropriate level of substance use disorder care.[2] The same should be true for other mental health conditions.

Strengthen Patient Rights to Timely Determinations

SB 791 includes essential – and, again, common-sense – provisions that determinations must be made within specified timeframes. It is particularly important that, for expedited reviews, the insurer must accept the attestation of the treating provider, who is best positioned to know whether delay will endanger the patient or others. Finally, we believe it is critical that, whenever an insurer fails to make a determination within the time limits required by SB 791, the requested care be approved. In states without such consequences, insurers routinely violate the timeframes, leaving patients and their families with little recourse. We strongly support this provision.

Increase Transparency on Denials and Data Reporting

We strongly support SB 791 provisions to increase transparency to patients when they are denied requested services. Too often, we see MH/SUD services denied with few details and little explanation, making it very difficult for individuals and families to understand why care was denied and with inadequate information to fight the denial. We also support strengthened data transparency provisions relating to denials of care. Every insurer should be required to collect and provide information relating to medical necessity denials annually to the Maryland Insurance Administration. Such information can help raise red flags, particularly where high denial rates or overturn rates on appeal can identify inappropriate utilization review practices.

Inseparable is grateful to Senator Klausmeier for introducing SB 791, and we respectfully request that the Committee favorably report this bill.

Thank you for the opportunity to testify.
Respectfully,

David Lloyd
Chief Policy Officer

[2] Legal Action Center and Partnership to End Addiction, "Spotlight on Medical Necessity Criteria for Substance Use Disorders, December 2020, https://www.lac.org/resource/spotlight-on-medical-necessity-criteria-for-substance-use-disorders#:~:text=The%20Spotlight%20recommends%20that%20States,criteria%20for%20medical%20necessity%20determinations.

SB 791 UR reforms testimony for AARP.pdf
Uploaded by: James Gutman
Position: FAV

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SB791 Health Insurance - Utilization Review – Revisions
Senate Finance Committee
FAVORABLE
February 21, 2024

Good afternoon, Chair Beidle and members of the Senate Finance Committee. I am Jim Gutman, a Columbia resident and lead health care advocacy volunteer for AARP Maryland. I'm also a member of the Stakeholder Council of the Maryland Prescription Drug Affordability Board representing the public, and a volunteer drug-plan counselor during the Medicare open-enrollment period for the State Health Insurance Assistance Program (SHIP) in Howard County. Today I'm representing AARP Maryland and its more than 850,000 members in the state in supporting SB791. We thank Senator Klausmeier for introducing this important bill, which will reduce or eliminate many of the biggest abuses now prevalent in medical utilization review (UR) programs.

UR, when used correctly, is a worthwhile tool for assuring that patients get appropriate care and insurers and pharmacy benefit managers do not absorb unneeded expenses that will get passed on in the health care system. But in recent years UR increasingly has been tampered with in ways that instead often prevent patients from getting the care they need in a timely and affordable manner. It also has created huge obstacles, including time constraints, difficulties for patients in getting needed treatment plans and medications, and processes so cumbersome and protracted that they often result in patients giving up on receiving the care and pharmaceuticals they need.

AARP believes that treatment certification decisions must be made at least as rapidly as the medical situation requires to protect the beneficiary's health and permit a meaningful appeal if needed. Denials must be accompanied, in AARP's view, by clear information on the reasons for the denial as well as clear instructions on how to appeal the denial in a time-effective manner. Those needs often aren't being met in UR methodologies now.

SB791 addresses these and other problems, including bringing prior authorization (PA) processes into the fully modern age with real-time information and online processes, in a comprehensive and thoughtful manner. Among other things, it would require an online process for making the PA decisions, which by their very nature are extremely time-sensitive since they relate to when patients can get the care recommended by their physicians and other providers. Archaic manual systems now often delay these decisions to an extent that compromises the health of seriously ill patients.

Another part of the bill that relates to the specific AARP concern mentioned above would limit the justifications for adverse PA decisions. It provides for an expedited reconsideration if the provider says the services are needed for a condition or illness that would "seriously jeopardize"

the member's life, including via behavioral-health conditions. The insurer also would have to make the appeal procedure easier for both enrollees and providers, including via a dedicated phone number for grievance-decision-related communications. This is common sense, as well as critical for sound decision making.

A related provision in SB791 would require the PA process to be linked to real-time information about a patient's out-of-pocket costs and about more affordable medication alternatives covered by the insurer. This again is common-sense use of available technology, as is the provision that an insurer could not charge the provider or patient for accessing this process.

The legislation also would aid patients by changing the minimum length of a PA from the current 30 days to as much as 90 days and the amount of notice needed before implementing new PA requirements, making clear that the patient can stay on the drug in question in the interim. Along similar lines, a provision in the bill allows a patient to stay on a medication if the insurer previously authorized the medication for that patient, who has been on the medication continuously, and the treating provider determines that the patient still needs the drug. The objective here is logical: to stop an insurer from in-effect forcing a patient to halt a drug that is effective for the patient's condition or disease so that a less costly drug — or even a costlier one in which third party has a financial incentive — can be tried.

Policies such as the latter are especially harmful for AARP's constituency of adults aged 50 and above who frequently have multiple underlying conditions and multiple medications that increase the chances of harmful interactions when new medications must be introduced because of UR decisions. Provisions to halt such policies are important for preventing harm to patients, especially older and more vulnerable ones, and help financially since costs rise when shortsighted policies result in patients suffering bad health outcomes.

AARP believes that beneficial UR programs must be designed to detect and deal with medical services underutilization that compromises patient health as well as with overutilization. SB791 does this.

For all these reasons and numerous others, AARP-Maryland and I urge you to give SB791 a favorable report. If you have questions or need follow-up, please contact Tammy Bresnahan at tbresnahan@aarp.org or by calling 410-302-8451. Thanks very much.

SB791_MPCAC_FAV_FIN_221.pdf
Uploaded by: Joe Bryce
Position: FAV

EXECUTIVE BOARD

MPCAC

MARYLAND PATIENT CARE AND ACCESS COALITION

February 20, 2024

VIA ELECTRONIC SUBMISSION
Pamela G. Beidle, *Chair*
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401-1991

Re: Support for S.B. 791 - Health Insurance – Utilization Review – Revisions

Dear Chairwoman Beidle:

We are writing to you on behalf of the Maryland Patient Care and Access Coalition ("MPCAC") to express our support for S.B. 791. Over the past two years, MPCAC has been working with other organizations on the topic of reforming the method for utilization reviews used by health insurance carriers to determine medical necessity, when a patient's medical provider orders certain healthcare services. One of the most important aspects of the legislation—reform of prior authorization—addresses a health insurance carrier's cost-control process that requires physicians and other health care professionals to obtain advance approval from the carrier before a specific service is delivered to a patient to qualify for payment coverage.[1] Too often, these prior authorization reviews cause significant delays and, at times, outright denials, of critical health care services for Maryland patients.

MPCAC strongly believes that S.B. 791 would allow Marylanders to obtain the treatment they need without unnecessary delay by reducing burdens of unnecessary prior authorization requirements, requiring more timely communication between providers and carriers, and having utilization reviews conducted by practitioners with the appropriate medical specialization to conduct the reviews. **MPCAC proudly supports S.B. 791 and stands ready to serve as an ongoing resource to the Senate Finance Committee in its efforts to reform and evaluate utilization review laws.**

[1] "What is prior authorization", American Medical Association, https://www.ama-assn.org/practice-management/prior-authorization/what-prior-authorization (July 12, 2022) last accessed Feb. 19, 2024.

The Maryland Patient Care and Access Coalition

For 20 years, the Maryland Patient Care and Access Coalition ("MPCAC") has been the voice of independent physician practices in the State that deliver integrated, high-quality, cost-efficient care to patients in the medical office and freestanding ambulatory surgical facility ("FASF") settings. With hundreds of physicians in the fields of gastroenterology, orthopaedic surgery, urology, pathology, medical oncology, radiation oncology, and anesthesiology, MPCAC's member medical practices cared for Marylanders in nearly two million patient visits during the past year. In addition, the physicians in MPCAC's member practices perform approximately 200,000 procedures in FASFs and endoscopy centers annually.

S.B. 791 - Changes to Prior Authorization

Maryland patients have long needed responsible legislation such as S.B. 791 to protect their access to timely medical care. Current law unnecessarily burdens patients with prior authorization obstacles in the following ways: (i) Marylanders with chronic conditions can be subject to a denial by a health insurance carrier of their annual reauthorization for the same treatment, despite the provider knowing the treatment works and no change in the patient's medical condition; and (ii) for dosage changes which are fully consistent with the FDA's dosage labels, Marylanders can be subject to prior authorization requirements. By enacting S.B. 791, these unnecessary and burdensome barriers to care would be removed.

One of MPCAC's Board members described the treatment of moderate to severe Crohn's Disease and Ulcerative Colitis, which often requires the use of biologic medication, which can be very expensive without coverage. The treatment of these diseases requires patients to continue to stick to their treatments to avoid what can be dangerous flare-ups which may require hospitalization and even surgery. Under current law, patients suffering from these diseases face receiving adverse decisions on continuing a biologic that they have been on for years despite providing medical records and being forced to jump through unnecessary administrative hurdles. Even when prior authorization is eventually obtained, the burdens on patients and medical practices result in delays to treatment, risking flare-ups, increasing patient anxiety, and ultimately adding to the cost of the care.

Similarly, the AMA found in a 2021 survey that: (a) 91% of respondents reported prior authorization can lead to negative clinical outcomes with 34% reporting serious adverse events in patients' care because of prior authorizations; and (b) 82% of respondents reported prior authorizations can cause patients to abandon their course of treatment.[2] Despite increased scrutiny and national attention to the issue of prior authorization, the 2022 Report on the Maryland Health Care Appeals and Grievances Law (released December 1, 2023), found that the number of adverse decisions from Maryland insurance carriers actually increased from 78,730 in 2019 to 95,327 in 2022, which is an increase of 21.1%.[3]

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[2] *See id*.

[3] See "2022 Report on the Health Care Appeals & Grievance Law Insurance Article § 15-10A-06," Maryland Insurance Administration, https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2022-Report-on-the-Health-Care-Appeals-and-Grievance-Law-MSAR-6.pdf (Dec. 1, 2023) last accessed Feb. 19, 2024.

Prior authorization roadblocks exist even for medical practices with very high rates of approvals, which demonstrates that the practices are providing medically necessary care based on the guidelines set by the carriers. S.B. 791 includes an important study on the feasibility of implementing a "gold card" standard in Maryland, which exempts healthcare providers who meet certain approval thresholds from prior authorization. We urge the General Assembly to pass S.B. 791, so that we can move forward with this study and, ultimately, the adoption of a "gold card" program in Maryland, which would allow patients to obtain treatment in a timelier manner.

S.B. 791 – Communication and Expertise of Reviewers

MPCAC also supports S.B. 791's requirements to increase transparency and communication as part of the review process. The bill requires health insurance carriers to (i) explain the reasoning of a denial with more specificity; and (ii) specifically request any additional information that they need to make a determination (e.g., lab, diagnostic tests, or other medical information), and to provide the criteria and standard used to support why they need such information. Additionally, the bill mandates that when a treating physician requests a "peer-to-peer" discussion, the health insurance carrier must provide such a peer-to-peer discussion (currently this is discretionary), and the health insurance carrier's representative must not only be board certified in the specialty, but also knowledgeable of and experienced in the particular diagnosis and course of treatment under review.

It is our understanding that in both 2022 and 2023, the Maryland Insurance Administration modified or reversed the carrier's decision (or the carrier reversed its own decision during the course of an investigation), more than 70% of the time on filed complaints. In other words, more than seven out of every ten times, a carrier's initial decision that created a barrier to patients receiving timely and appropriate care was overturned. MPCAC believes that the changes set forth in S.B. 791 will help reverse this disturbing statistic.

We believe S.B. 791 is a necessary step towards helping Maryland's health care providers deliver—and patients receive—the health care services needed without the delays and burdens allowed under existing law. MPCAC looks forward to continuing to serve as a trusted partner to members of the General Assembly as we work together to confront the challenges and opportunities facing our health care system and to promote and protect the high quality, cost-efficient and convenient care furnished in the independent medical practice setting.

Sincerely,

Nicholas P. Grosso, M.D.
Chairman of the Board & President, MPCAC

Michael Weinstein, M.D.
Chair, Health Policy, MPCAC

cc: All Senate Finance Committee Members
Joe Bryce, Manis Canning

MD_ SB791_Letter of Support.pdf
Uploaded by: Lindsay Gill
Position: FAV

February 20, 2024

The Honorable Pamela Beidle
Chair, Senate Finance
Room 3 East Wing, Miller Senate Office Building,
11 Bladen Street, Annapolis, MD 21401-1991

Re: Support for SB 791 - Health Insurance - Utilization Review - Revisions

The Honorable Chair Beidle, Vice Chair Klausmeier, and Members of the Finance Committee:

On behalf of The ALS Association and the families we serve in Maryland, we urge you to support **SB 791 - Health Insurance - Utilization Review - Revisions**, which will reform the prior authorization process and have a positive impact on people living with ALS.

ALS is a progressive neurodegenerative disease that affects the nerve cells responsible for controlling voluntary muscle movement. It is a devastating condition that leads to the gradual loss of muscle function, eventually rendering individuals unable to speak, eat, or breathe independently. Given the severity and rapid progression of ALS, timely access to necessary medical interventions, treatments, and support services is paramount.

Currently, the prior authorization process poses significant obstacles and delays for ALS patients, impeding their access to critical treatments and therapies. According to the AMA, 91% of physicians said that prior authorization requirements had a *somewhat or significant* negative impact on patients' clinical outcomes[1]. In addition, the cumbersome nature of prior authorization requirements not only undermines the quality of care but also exacerbates the physical, emotional, and financial burdens faced by people living with ALS and their families.

Implementing reform in prior authorization practices would alleviate these burdens and enhance the quality of life for people living with ALS. The following are key benefits that reform would bring:

1. **Timely Access to Care:** Eliminate unnecessary delays in accessing treatments, therapies, medications, and assistive devices. Prompt initiation of these interventions is vital to slow disease progression and provide maximum relief and support to patients.
2. **Reduced Administrative Burden:** Reforming this process would allow healthcare professionals to focus on delivering timely and comprehensive care to people living with ALS.
3. **Enhanced Patient-Physician Relationship:** A strong patient-physician relationship is crucial in managing ALS effectively, ensuring that treatment decisions are made collaboratively and tailored to the specific needs of the individual.
4. **Improved Quality of Life:** Swift access to interventions such as mobility aids, speech therapy, nutritional support, and palliative care can significantly enhance the quality of life for people living with ALS.

[1] https://www.ama-assn.org/practice-management/prior-authorization/why-prior-authorization-bad-patients-and-bad-business

5. **Financial Relief:** Reforms in the prior authorization process would reduce out-of-pocket expenses, lessen the need for appeals, and provide financial relief to those grappling with mounting healthcare costs.

We also wanted to highlight this extremely important provision that has been a priority since last year's introduction. This provision prohibits an insurer or PBM from issuing an adverse decision on a reauthorization for the same prescription drug or request additional documentation from the prescriber for the reauthorization request if: **(i) the entity previously approved a prior authorization for the prescription drug for the insured; (ii) the insured has been treated with the prescription drug without interruption since the initial approval of the prior authorization; and (iii) the prescriber attests that, based on the prescriber's professional judgment, the prescription drug continues to be necessary to effectively treat the insured's condition (page 7, lines 11-22).** Patients are routinely harmed when insurers approve a prescription drug for a year and then take that drug away from the patient. This creates a never-ending cycle where the patient is subjected to repeated drug changes based on formulary and savings to the insurers without protection to the patient.

In conclusion, I implore the committee to support this bill and recognize the pressing need for prior authorization reform, particularly concerning the care of people living with ALS. By implementing more efficient and patient-centered processes, you can positively impact the lives of countless individuals living with this devastating disease. Please consider taking decisive action to improve the prior authorization system.

Thank you for your attention and anticipated support. I remain hopeful that together, we can make a tangible difference in the lives of those affected by ALS.

Should you require further information or wish to discuss this matter, please do not hesitate to contact me at Lindsay.gill@als.org

Sincerely,

Lindsay Gill

Lindsay Gill
Managing Director, Advocacy
ALS Association

LRD Testimony.pdf
Uploaded by: Lucy Davies
Position: FAV

From:
Lucy Davies, BSN, RN, AE-C
Division of Pediatric Pulmonology, Allergy, and Sleep
University of Maryland

To: Members of the Senate Finance Committee
Re: Senate Bill 791 (House Bill 932) - Health Insurance - Utilization Review - Revisions Date: February 21, 2024
Position: Support
Dear Chair Beidle, Vice Chair Klausmeier, and members of the Committee,

I am writing in support of Senate Bill (SB) 791. Prior authorizations are requests by medical providers for insurances to cover medications that are not on formulary. This can be because the patient requires a higher level of medication, needs to remain on their current therapy, has a contraindication to a covered alternative, etc. SB 791 would prohibit insurers from denying coverage for a patient's medication if 1) they had previously approved the drug for the patient, 2) the patient has been continuously treated with the drug since the approval, and 3) the patient's health care provider attests that the patient needs the medication. It would also require insurers to create an online system for use by health care providers that would streamline the prior authorization process. This is extremely important to ensure patients receive their medications in a timely manner. In some cases patients have to wait up to 30 days to receive a determination and in many cases the medication is still denied.

I have been a provider in an outpatient pediatric asthma clinic for a little over a year. Within that one year, the number of times the formularies have changed for different insurances has been on average 2-4 times. When insurances change their formularies, medications that were previously covered are often removed completely. An example of this would be Maryland Physicians Care. Prior to January 1st 2024, they covered a medication called fluticasone-salmeterol, generic Advair, which is a combination therapy MDI (metered dose inhaler). We prescribed many patients this medication whose symptoms could not be managed by a single therapy inhaler (ex. Flovent). When this medication was removed, dozens of patients lost their coverage. The only remaining covered options are "dry powder inhalers." These require a lot of coordination to use them effectively, which most young children are not able to do. They need what is called an "HFA"/MDI inhaler - a spray inhaler that can be used with a spacer/mask - to make sure they get their medication effectively. This is thoroughly documented by multiple studies/research. There is no longer any covered combination therapy inhaler available on formulary for Maryland Physicians Care.

We encounter issues like these on a daily basis. In the week following January 1st 2024, I personally submitted over 75 prior authorizations (usually taking upwards of 30 minutes each) for previously covered inhalers that are now denied. The process for appealing the denials is lengthy and can take 2-30 days to receive a determination from an insurance company. Oftentimes, even after that, the drug is still denied.

Requiring patients to wait to receive or not being able to receive these medications at all is completely unacceptable. Lack of a maintenance inhaler can cause extreme exacerbations of symptoms, leading to illness, flare-ups of symptoms, emergency visits, hospital admissions, and, in extreme cases, death. Just today, I received a denial of an appeal for an inhaler for a 4-year old patient. This was the final option to get his medication approved, and there are no covered

appropriate alternatives. They stated in the denial letter that one of the reasons it could not be approved was because the patient "had no emergency room or urgent care visit for asthma" since his last appointment. This is essentially saying the insurance will not cover his inhaler until his symptoms are so serious that they require hospitalization. It is sickening that this is what is required for a child to simply be able to breathe.

For the reasons explained above, I respectfully request that the Committee issue a favorable report on SB 791.

Lucy Davies, BSN, RN, AE-C
Division of Pediatric Pulmonology, Allergy, and Sleep
University of Maryland

Support URBill.pdf
Uploaded by: Malinda Duke
Position: FAV

NURSE PRACTITIONER
Association of Maryland

"Advocating for Nurse Practitioners since 1992"

Bill: Senate Bill 791/House Bill 932

Position: Support

Dear Chair, Vice Chair, and Members of the Committee:

On behalf of the Nurse Practitioner Association of Maryland (NPAM), representing 849 nurse practitioners in the State, I am writing to express our support for Senate Bill 791/House Bill 932.

Utilization review techniques, particularly prior authorization and step therapy, have become significant barriers to patient care, often resulting in delays, denials, and unnecessary administrative burdens for both patients and healthcare providers. The statistics from the 2022 Report on the Maryland Health Care Appeals and Grievances Law are alarming, indicating a substantial increase in adverse decisions by insurance carriers, adversely affecting patient outcomes and adding to healthcare costs.

The proposed legislation addresses several key issues in utilization review, with a focus on streamlining processes, enhancing transparency and communication, and ultimately prioritizing patient care. The provisions outlined in the bill, such as prohibiting denials for medication renewals when previous approval has been granted and ensuring timely communication and explanation of denial decisions, are essential steps toward mitigating the adverse impact of utilization review on patients.

Furthermore, the emphasis on increasing transparency, providing dedicated call lines for denials, and mandating peer-to-peer reviews when requested by healthcare providers are critical measures to foster better communication and collaboration between insurers and healthcare professionals. By aligning review criteria with established medical standards and ensuring that decisions are based on clinical expertise, we can uphold the integrity of the healthcare system and prioritize the needs of our patients.

We are also in strong support of the provision prohibiting an insurer/PBM from issuing an adverse decision on a reauthorization for the same prescription drug or request additional documentation from the prescriber for the reauthorization request if: (i) the entity previously approved a prior authorization for the prescription drug for the insured; (ii) the insured has been treated with the prescription drug without interruption since the initial approval of the prior authorization; and (iii) the prescriber attests that, based on the

prescriber's professional judgment, the prescription drug continues to be necessary to effectively treat the insured's condition (page 7, lines 11-22).

Patients are routinely harmed when insurers approve a prescription drug for a year and then take that drug away from the patient – not because the drug isn't effectively managing their symptoms but because the insurer's formulary has changed (often due to rebates), and the patient is now being forced off a drug to take a cheaper drug. This creates a never-ending cycle where the patient is subjected to repeated drug changes based on formulary and savings to the insurers without protection to the patient. Too often, this results in a bad health outcome for the patient.

I commend the collaborative efforts of the General Assembly, healthcare practitioners, patient advocacy organizations, and insurance carriers in developing this legislation. It reflects a commitment to addressing the challenges posed by utilization review techniques and striving for a more patient-centered approach to healthcare delivery.

In conclusion, I urge you to support Senate Bill 791/House Bill 932 and advocate for its passage to enact meaningful reforms that will improve patient access to care, enhance transparency and communication in the utilization review process, and ultimately, promote better health outcomes for all Maryland residents.

For these reasons, we respectfully request a favorable report.

Sincerely,

Malinda D. Duke CRNP-PC

Malinda D. Duke CPNP-PC, CDCES
Executive Director, NPAM
5372 Iron Pen Place
Columbia, MD 21044NPAMexdir@npedu.com
443-367-0277 (office)
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Scan_20240220 (3).pdf
Uploaded by: Marilyn Mongilio
Position: FAV

From: Marilyn Mongilio, R.N., Pediatric Pulmonology, Allergy and Sleep Medicine

To: Members of the Senate Finance Committee

Re: Senate Bill 791 (House bill 932)-Health Insurance-Utilization Review-Revisions

Date: February 21, 2024

Position: Support

Dear Chair Beidle, Vice Chair Klausmeier, and members of the Committee,

I am writing in support of Senate Bill (SB) 791. Prior Authorizations are required when a physician requests a medication that is not on the insurance company formulary. It is very important for patients to be able to receive the medications prescribed by their physicians to keep them out of the hospital and also for patient compliance. Senate Bill 791 would prohibit insurers from denying coverage for a patient's medication if they 1) had approved the drug for the patient previously, 2) the patient has been continuously treated with the drug since approval, and 3) the patient's health care provider attests that the patient needs the medication. It would require insurers to create an online system for use by the health care providers that would streamline the PA process. This is important so patients would not have a gap in taking their medications therefore, preventing "flares" in their illness.

I have been a nurse for over 30 years and have worked in Pediatric Pulmonary, Allergy and Sleep Medicine for over 20 years. In the last couple of years, I have seen a major change in insurance company's dictating what medications our physicians can prescribe. It has caused confusion with our patients when the medications switch so often (at least once a year) when the formulary changes. This leads to patients having to wait for medications and also can cause non compliance. Today, I was following up on a denied prior authorization. I had asked for an override so the family could receive at least medication while they waited for 15-30 days to see if denial was overturned. I explained to numerous people that the patient is 6 years old and cannot take the combination medication that is on the formulary. This patient has been admitted 3 times in the last 12 months and was doing well on his medication until his insurance decided they would not cover it. The only combination medication requires the patient to inhale and hold their breath for 6 seconds. Some of our patients cannot perform this type of administration. As I was on hold and passed to each department within PA department, after an hour, I was disconnected. I called back again and finally received the override. In total I was on the phone for 1 hour and 35 min not including my time spent on Fri working on same patient. We see many patients and spend hours each day working on PA's and denials when we should be spending on our patients.

2024 SB791 Testimony.pdf
Uploaded by: Michael Huber
Position: FAV

JOHNS HOPKINS
UNIVERSITY & MEDICINE

SB 791
Favorable

TO: The Honorable Pamela Beidle, Chair
Senate Finance Committee

FROM: Michael Huber
Director, Maryland Government Affairs

DATE: February 21, 2024

RE: SB 791 - Health Insurance - Utilization Review - Revisions

Thank you for the opportunity to submit this written testimony on behalf of Johns Hopkins University & Medicine. Johns Hopkins urges a favorable report on **SB 791 - Health Insurance - Utilization Review - Revisions.** SB791 reduces the volume of prior authorization requirements and increases transparency and communication.

Insurance companies have utilization review practices, including prior authorization, that force doctors and patients to obtain approval for specific medicine, treatment, medical device, or procedure before the insurer will pay for it. 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

SB 791 makes changes to the utilization review policies used by health insurance carriers to determine when a requested health care service is medically necessary. It will help ensure that decisions by providers are made timely and are based on appropriate clinical and medical standards. Most importantly, SB 791 contains a provision that will allow a patient to remain on a medication when that medication was previously approved by the patient's insurance company and the patient has been well-maintained on that medication. Most often, this scenario affects patients with serious mental illness or other chronic conditions (i.e., autoimmune diseases, hypertension, diabetes) whose treatment plan requires the use of maintenance drugs.

Utilization review policies used by insurance carriers negatively affect patients by either denying or delaying necessary care. These delays lead to a backup in our emergency departments as patients await insurance approval to discharge to post-acute facilities. At times, these decisions can take up to a week. These delays pose a safety risk to the patients in our emergency departments and those sitting in hospitals awaiting their next level of care. Health insurance carriers will then deny the days related to their own decision making as lacking medical necessity.

JOHNS HOPKINS
UNIVERSITY & MEDICINE

A recent survey by the American Medical Association found that 93% of physicians reported delays in access to necessary care and 82% of physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials. Data from the Maryland Insurance Administration's (MIA) 2022 Report on the Health Care Appeals and Grievances Law (released December 1, 2023) is further evidence that carriers need to be constrained from using prior authorizations as the number of denials of care continue to increase year after year. In 2022, the number of denials reported from the insurance carriers to the MIA was 95,327 whereas in 2021 that number was 81,143. Moreover, 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.

Senate Bill 791 will improve this process for patients and providers by achieving the following:

1. **Reducing/Streamlining the Volume of Prior Authorization Requirements**

    a. Prohibiting a carrier from issuing a denial of care when a patient requests a medication renewal if the insurer previously approved the drug, the patient has been successfully treated on the prescription drug, and the prescriber attests that the patient continues to need the drug.
    b. Exempting prescription drugs from requiring a prior authorization for dosage changes provided that the change is consistent with federal FDA labeled dosages and is not an opioid. ** *Maryland law already prohibits prior authorization for a prescription drug when used for treatment of an opioid use disorder and that contains methadone, buprenorphine, or naltrexone.*
    c. Requiring a carrier to allow a patient who changes health insurance carriers to remain on the patient's medication for a period of the lesser of 90 days or the course of treatment doing which time the new carrier can perform its own prior authorization review.
    d. Requiring a carrier to provide 60 days' notice rather than the current 30 days' notice when it implements a new prior authorization requirement.
    e. Requiring that a carrier, when approving a prior authorization request, to approve a course of treatment of a non-medication health care service for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation.

2. **Increasing Transparency and Communication as Part of the Review Process**

    a. Ensuring that the decision of when a case requires an expedited review after a denial is based on the determination of the health care provider and not the carrier (i.e., expedited reviews must be conducted within 24 hours).

b. Requiring that any communication from the carrier where there is a denial of health care services states in detail the factual bases for the decision that explains the reasoning why the health care provider's request was not medically necessary and why it did not meet the criteria and standards used in conducting the review, which must be specifically referenced and not simply referred to "as part of the member's policy or plan document."
c. Requiring carriers to have a dedicated call line or dedicated/monitored email address for denials so that health care providers can discuss the decision or schedule a time to discuss with the carrier rather than having to go through the general customer call line.
d. Requiring that if any additional information is needed to make the determination the carrier must provide the specific information needed, including any lab or diagnostic test or other medical information, along with the criteria and standard used to support the need for the additional information.
e. Adding new reporting requirement within the annual report on utilization review by the Maryland Insurance Administration to determine how many patients requested a formulary or copay tier exception when changes have occurred to either.
f. In addition to satisfying other factors, eliminating "homegrown" criteria in favor of requiring carriers to utilize criteria and standards that are developed by nonprofit medical or clinical specialty societies or organizations that work directly with health care providers in the same specialty.
g. Mandating that a "peer to peer" must occur if requested by the health care provider (currently – it is discretionary).
h. Mandating that if the carrier does not meet the required times for making a determination the request is deemed approved.

3. **Future Review Changes**

a. Studying whether to implement changes to the prior authorization requirements based on a health care provider's prior practice (otherwise known as the "gold card")
b. Reviewing whether to eliminate prior authorization requirements when a health care provider participates in a value-based arrangement.
c. Imposing a future requirement (2026) that carriers' electronic processes must integrate with all electronic health records to provide real time benefit information on a patient's coverage at no cost to the health care provider.

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.

JOHNS HOPKINS
UNIVERSITY & MEDICINE

Johns Hopkins University & Medicine urges the committee to issue a **favorable** report on **Senate Bill 791**.

Thank you for your time and consideration.

Sincerely,

Michael Huber
Director, Maryland Government Affairs
Johns Hopkins University and Medicine

2024 ACNM SB 791 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

Support

Senate Bill 791 – Health Insurance - Utilization Review - Revisions

Senate Finance Committee

February 21, 2024

The Maryland Affiliate of the American College of Nurse-Midwives supports Senate Bill 791 – *Health Insurance - Utilization Review - Revisions*. The bill alters the requirements for providers and carriers related to health insurance utilization review including provisions regarding benchmarks for standardizing and automating the preauthorization process, and the online preauthorization system for payors, preauthorization for prescription drugs, and private review agents. Additionally, the bill alters the timelines related to internal grievance procedures and adverse decision procedures.

ACNM supports this legislation because preauthorization has become an overly complicated burden for providers and most importantly delays care for our patients. Carriers have each created their own preauthorization process which means there is little conformity between carriers which complicates the preauthorization process and ultimately leads to more denials. As the Maryland Insurance Administration (MIA) has stated in there 2022 Report on the Health Care Appeals and Grievances Law, carriers rendered 95,327 adverse decisions (e.g., denials of health care services based on the carrier's decision that the health care service was not medically necessary rather than the judgment of the treating practitioner). In the same report the MIA modified or reversed the carrier's decision (or the carrier reversed it during the course of investigation), 71% of the time on filed complaints. ACNM believes that this bill will address a number of the burdens the utilization review system has placed on providers and patients and ultimately improve the health outcomes for patients.

We ask for a favorable report on this legislation. If we can provide any additional information, please contact Michael Paddy at mpaddy@policypartners.net.

2024 LCPCM SB 791 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 791**

Title: **Health Insurance – Utilization Review – Revisions**

Hearing Date: **February 21, 2024**

Position: **Support**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) supports Senate Bill 791 - *Health Insurance – Utilization Review – Revisions.* The bill alters the requirements for providers and carriers related to health insurance utilization review including provisions regarding benchmarks for standardizing and automating the preauthorization process, and the online preauthorization system for payors, and preauthorization for prescription drugs, and private review agents. Additionally, the bill alters the timelines related to internal grievance procedures and adverse decision procedures.

LCPCM supports this legislation because the current law allows too many inconsistencies between carriers which makes the preauthorization process unnecessarily burdensome for our members and delays the care our patients require. Specifically the practice of insurers approving a prescription drug for a year and then abruptly discontinuing it can have serious consequences for patients. It is often not because the drug is not effectively managing their symptoms, but rather due to changes in the insurer's formulary, which are often driven by financial considerations such as rebates. As a result, patients are forced to switch to a cheaper alternative, creating a never-ending cycle of repeated drug changes based on formulary and savings to the insurers. Unfortunately, this lack of protection for patients can lead to negative health outcomes. It is crucial that insurers prioritize the well-being of patients over cost-saving measures to ensure better healthcare outcomes. This bill would address this concern.

We ask for a favorable report on this legislation. If we can provide any further information, please contact Michael Paddy at mpaddy@policypartners.net

2024 MCHS SB 791 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill: **SB 791 - Health Insurance - Utilization Review - Revisions**

Hearing Date: **February 21, 2024**

Position: **Support**

The Maryland Community Health System (MCHS) supports Senate Bill 791 - *Health Insurance - Utilization Review - Revisions*. The bill would alter the requirements for providers and carriers related to health insurance utilization review which would include the provisions regarding benchmarks for standardizing and automating the preauthorization process, and the online preauthorization system for payors, and preauthorization for prescription drugs, and private review agents. Additionally, the bill would alter the timelines related to internal grievance procedures and adverse decision procedures.

As a network of federally qualified health centers, we provide somatic, behavioral, and oral health service to underserved communities. Our practitioners spend a significant amount of time navigating the unneeded complexities of the preauthorization process. Our clinicians could spend more time on direct patient care if the preauthorization process was standardized across carriers.

One of the most meaningful provisions in the bill would prohibit an insurer from issuing an adverse decision on a reauthorization for the same prescription drug or request additional documentation from the prescriber for the reauthorization request if: (i) the entity previously approved a prior authorization for the prescription drug for the insured; (ii) the insured has been treated with the prescription drug without interruption since the initial approval of the prior authorization; and (iii) the prescriber attests that, based on the prescriber's professional judgment, the prescription drug continues to be necessary to effectively treat the insured's condition. Patients are routinely harmed when insurers approve a prescription drug for a year and then take that drug away from the patient – not because the drug is not effectively managing their symptoms but because the insurer's formulary has changed and the patient is now being forced off a drug to take a different drug. This creates a never-ending cycle where

the patient is subjected to repeated drug changes based on formulary and savings to the insurers without protection to the patient.

We ask for a favorable report. If we can provide any further information, please contact Michael Paddy at mpaddy@policypartners.net

2024 MNA SB 791 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 791 – Health Insurance – Utilization Review – Revisions**

Hearing Date: **February 21, 2024**

Position: **Support**

The Maryland Nurses Association (MNA) supports Senate Finance 791 – *Health Insurance – Utilization Review – Revisions*. The bill would alter the requirements for providers and carriers related to health insurance utilization review which would include the provisions regarding benchmarks for standardizing and automating the preauthorization process, and the online preauthorization system for payors, and preauthorization for prescription drugs, and private review agents. Additionally, the bill would alter the timelines related to internal grievance procedures and adverse decision procedures.

MNA supports this legislation because the current law, in practice, has created more hurdles and roadblocks for providers trying to deliver care to their patients, and most importantly timely care to their patients. The current prior authorization process often involves lengthy wait times and unnecessary administrative burdens for healthcare providers. This can delay patients' access to necessary treatments and services, resulting in potential harm or deteriorating health conditions. It is crucial that these requirements are revised to ensure that patients receive timely and appropriate care without unnecessary obstacles.

The current system also places an undue burden on healthcare providers. The administrative tasks associated with obtaining prior authorizations can be time-consuming and take away valuable resources that could be better utilized for direct patient care. By updating the utilization review requirements, providers can focus on delivering high-quality care to their patients. It is evident that the current system primarily benefits insurance carriers. The strict authorization requirements often lead to denials or delays in approvals, allowing insurance companies to save costs. However, this approach disregards the best interests of patients who

may be left without essential treatments or forced to seek alternatives that may not be as effective.

We ask for a favorable report. If we can provide any additional information, please contact Michael Paddy at mpadd@policypartners.net.

2024 MOTA SB 791 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

Maryland Occupational Therapy Association

PO Box 36401, Towson, Maryland 21286 ♦ www.mota-members.com

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 791 - Health Insurance - Utilization Review - Revisions**

Hearing Date: **February 21, 2024**

Position: **Support**

The Maryland Occupational Therapy Association (MOTA) supports Senate Bill 791 - *Health Insurance - Utilization Review - Revisions.* The bill would alter the requirements for providers and carriers related to health insurance utilization review which would include the provisions regarding benchmarks for standardizing and automating the preauthorization process, and the online preauthorization system for payors, and preauthorization for prescription drugs, and private review agents. Additionally, the bill would alter the timelines related to internal grievance procedures and adverse decision procedures.

Occupational therapy services are effective in assisting individuals to manage chronic conditions more effectively, thereby improving their quality of life and ability to engage in meaningful occupations, while decreasing frequency of medical interventions. The bill also requires carriers to eliminate "homegrown" medical criteria in favor of requiring carriers to utilize criteria and standards that are developed by a nonprofit medical or clinical specialty societies or organizations that work directly with health care providers in the same specialty relevant to the clinical diagnosis. This will help establish uniformity between insurance carriers. Additionally, the bill requires mandating that a "peer to peer" must occur if requested by the health care provider and that the licensed provider must not only be board certified or eligible in the same specialty but also knowledgeable about the requested health care service or treatment through actual clinical experience. This again will help establish uniformity among insurance carriers and would make the denial process more transparent.

We ask for a favorable report. If we can provide any additional information, please feel free to contact Michael Paddy at mpaddy@policypartners.net.

SB791 FAV.pdf
Uploaded by: Morgan Mills
Position: FAV

NAMI Maryland
National Alliance on Mental Illness

February 21, 2024

Chairwoman Beidle, Vice Chair Klausmeier, and distinguished members of the Finance Committee,

NAMI Maryland and our 11 local affiliates across the state represent a network of more than 58,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a 501(c)(3) non-profit dedicated to providing education, support, and advocacy for people living with mental illnesses, their families, and the wider community.

SB791 aims to reform utilization review standards, in part by addressing the incredibly important topic of patient access issues.

The complexity of navigating the healthcare and insurance system is already a major obstacle for individuals seeking mental health care. The process can be incredibly overwhelming. Additional barriers exist for people with mental illness.

NAMI MD is adamant that individuals with mental illness have access to clinically appropriate medications. This is of increased importance for mental health care, because psychiatric medications influence the brain chemicals that regulate emotions and thought patterns. Because these medications deal with brain chemistry, stopping a medication suddenly can have bad effects. It may worsen the problem it was treating, or for some medications, it can cause a more serious problem.

This bill begins to address patient access issues by:

- Prohibiting a carrier from issuing a denial of care when a patient requests a medication renewal if the insurer previously approved the drug, and the patient has seen success on that drug.
    - NAMI MD believes that no one currently taking a medication and doing well on that medication should be switched to another medication, even the generic version of the original, simply because the second medication is cheaper. Additionally, finding the right drug for mental health conditions is tricky—there is no need to switch the patient to another drug if they are successful.

- Exempting prescription drugs from requiring prior authorization for dosage changes (so long as the change is consistent with FDA labeled dosages).
    - In many cases, providers start their patients at a low dose and slowly increase dosage to achieve a level that improves symptoms. By exempting this from prior authorization, we are allowing patients to access the care that they need.

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

- Requiring that any communication from the carrier when there is a denial states the factual basis for the decision.
    - Too often, denials are referred to “as part of the member’s policy or plan document”. As aforementioned, navigating insurance as a person with mental illness is already challenging. Requiring a factual basis will help patients appeal their denials easier.

- Requires carriers to have a dedicated call line or dedicated and monitored email address for scheduling when a denial has been issued so that health care providers can discuss the decision, rather than going through the general call line.
    - In many instances, providers spend hours trying to appeal decisions for their patients. The procedure is complicated and time consuming.

- Requiring carriers to utilize criteria and standards that have been developed by nonprofit medical or clinical specialty society or organization.
    - This increases transparency and allows providers to have a better understanding of how those standards can be met.

This bill will reduce the volume of prior authorization requirements and will decrease the amount of inappropriately issued denials. By doing so, we are increasing patient access and vulnerable Marylanders can get the care they need in a timely manner.

For these reasons, we urge a favorable report.

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

SB0791-FIN-SUPP.pdf
Uploaded by: Nina Themelis
Position: FAV

BRANDON M. SCOTT
MAYOR

Office of Government Relations
88 State Circle
Annapolis, Maryland 21401

SB0791

February 21, 2024

TO: Members of the Senate Finance Committee

FROM: Nina Themelis, Director of Mayor's Office of Government Relations

RE: Senate Bill 791 – Health Insurance - Utilization Review - Revisions

POSITION: FAVORABLE

Chair Beidle, Vice Chair Klausmeier, and Members of the Committee, please be advised that the Baltimore City Administration (BCA) **supports** Senate Bill (SB) 791.

SB 791 changes the "prior authorization" (prior auth) process, which insurance companies use to review treatments prescribed by medical providers and to control costs. **The current prior auth process is burdensome to health care providers and often leads to harmful disruptions in critical patient care.** National medical experts, including the American Medical Association and American Hospital Association, have been advocating for changes to this process for years.[i,ii,iii] SB 791 addresses some of the most pressing prior auth challenges.

SB 791 will allow people who take medication for chronic conditions to continue to use the medication that works for them by prohibiting insurers from denying coverage for a patient's medication if certain conditions are met. **This will be a major achievement in patient-centered care.** Patients should be treated with the medications that are most effective for them – not the medication that is cheapest for the insurer.

To understand the patient experience, let us examine what this can mean for children with asthma. 26% of Maryland high schoolers have asthma. In Baltimore City, this number is even higher, at 33%.[iv] To help make sure children have the medication they need to control their asthma, **the American Lung Association has urged states to "end policies that require patients to change medications when [their asthma is] already well controlled."** [I] It can take years to find a treatment that works for people with chronic conditions. When a prior auth request is denied, patients can find themselves suddenly switched to another drug by their insurer (not by their doctor). This can dramatically impact their health and quality of life.[v] **Over half of chronic disease patients subject to such medication changes experience new complications**.[v,vi] For asthma patients, this can mean increased asthma attacks, hospitalizations, missing school, loss of workdays, and even death.

These prior auth processes are costly to patients' health, their wallets, and to our entire health care system: while the initial decision to deny a prior auth request may save money for the insurer, downstream disruptions in patient care can ultimately increase net costs.[vii,viii] While insurers defer costs onto patients, they continue to reach record profits. In the third quarter of 2022 alone, Cigna shareholders saw $2.8 billion in income.[ix] UnitedHealth Group saw $5.3 billion in net earnings.[x] That same year, a college student in

Pennsylvania was fighting to get UnitedHealth to cover the only treatment that worked for his debilitating ulcerative colitis. The company, which continuously refused despite advocacy from his doctor, earned in just minutes what it would cost to cover his treatment for a year.[xi]

In addition to the critical changes to the prior auth process described above, **SB 791 also increases transparency and facilitates communication between health care providers and insurers.** As part of this, it requires insurance companies to implement an online system that streamlines the prior auth process. This would be a boon to health care workers, who often spend hours every day navigating complex prior auth processes – all hours during which they could otherwise be seeing patients.[vii]

For these reasons, the BCA respectfully request a **favorable** report on SB 791.

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[ii] American Medical Association. (2024). Prior authorization reform initiatives. Retrieved from https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-reform-initiatives

[iii] American Hospital Association. (2023). AHA Urges CMS to Finalize the Improving Prior Authorization Processes Proposed Rule. Retrieved from https://www.aha.org/lettercomment/2023-10-27-aha-urges-cms-finalize-improving-prior-authorization-processes-proposed-rule

[iv] Maryland Department of Health. (n.d.). 2018 Youth Risk Behavior Survey Results. Retrieved from https://health.maryland.gov/phpa/ccdpc/Reports/Documents/2018%20YRBS%20YTS%20Reports/Maryland/2018MDH%20Detail%20Tables.pdf

[v] Alliance for Patient Access. (2019). A study of the qualitative impact of non-medical switching. Retrieved from https://admin.allianceforpatientaccess.org/wp-content/uploads/2020/02/AfPA_Qualitative-Impact-of-Non-Medical-Switching_Report_Feb-2019.pdf

[vi] Gilbert I, Wada K, Burudpakdee C, Ghai C, Tan L. The Impact of a Forced Non-Medical Switch of Inhaled Respiratory Medication Among Patients with Asthma or Chronic Obstructive Pulmonary Disease: A Patient Survey on Experience with Switch, Therapy Satisfaction, and Disease Control. Patient Prefer Adherence. 2020;14:1463-1475. Published 2020 Aug 20. doi:10.2147/PPA.S242215

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[viii] Liu, Y., Skup, M., Lin, J., & Chao, J. (2015). Impact of non-medical switching on Healthcare costs: a claims database analysis. DOI: https://doi.org/10.1016/j.jval.2015.03.1465

[ix] The Cigna Group. (2022). Cigna Reports Strong Third Quarter 2022 Results, Raises 2022 Outlook. Retrieved from

[x] UnitedHealth Group. (2022). UnitedHealth Group Reports Third Quarter 2022 Results. Retrieved from https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2022/UNH-Q3-2022-Release.pdf

[xi] Armstrong, D., Rucker, P. & Miller, M. (2023). UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings. Retrieved from https://www.propublica.org/article/unitedhealth-healthcare-insurance-denial-ulcerative-colitis

Progressive Maryland’s Testimony in Support of SB
Uploaded by: Patty Snee
Position: FAV

Testimony in Support of SB 791
An Act Concerning Health Insurance-Utilization Review-Revisions
Senate Finance Committee

February 20th, 2024

Dear Honorable Chair Pamela Beidle, Vice Chair Klausmeier and Members of the Committee,

Progressive Maryland, a statewide non-profit grassroots organization with 20,000 individual members and supporters, 4 local chapters, and 21 affiliated labor, civil rights, health and environmental groups, appreciates the opportunity to present written testimony in support of SB 791.

This is a critical year for the Committee and the Maryland General Assembly to take up measures like this in order to address the alarming increase in care, coverage and claims denials being issued by health insurance carriers in our state and around the country. We started a Care Over Cost grassroots campaign last summer and in our conversations with people on their doorsteps or at community events we are learning how confusing, stressful, and almost impossible it is for many people to use their health policies for provider recommended care. They try to navigate the process as best they can but even with help from their providers they often don't get a resolution in their favor. Some give up pursuing the appeal or claim because they simply don't have the time and energy it requires. Of course when that happens people run the risk of getting sicker, needing to rely on the ER for their care, or having unreimbursed bills.

Everyday Marylanders are very concerned that the pre-authorization process has gotten out of hand. They can't understand why carriers are delaying or denying provider recommended care. It's also not lost on them that the system is spending a great deal of time and money on processes that amount to creating barriers to care.

Closer review and regulations of these processes will help ensure that patients and providers have more power over critical healthcare decisions. Patients should be able to get the care they need when and where they need it and this legislation supports that goal. We urge you to pass SB 791 and to encourage your Senate colleagues to do the same.

Thank you for your consideration.

Patty Snee
Progressive Maryland Staff
On Behalf of Progressive Maryland's Healthcare Task Force
District 20 Voter

UR Support Senate Bill 791 MPMA.pdf
Uploaded by: Sarah Peters
Position: FAV

MARYLAND PODIATRIC MEDICAL ASSOCIATION

The Adams Building, Suite 301
600 Baltimore Avenue
Towson, Maryland 21204

Telephone: (410) 332-0736
Facsimile: (410) 332-0885

February 16, 2024

Senator Pamela Beidle, Chair
Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

SB791: Health Insurance - Utilization Review - Revisions

Position: Support

Dear Chair Beidle, Vice Chair Klausmeier, and Members of the Committee:

On behalf of the MD Podiatric Medical Association (MPMA), representing over 250 podiatrists in Maryland and the practice of podiatry, I am writing to express our support for Senate Bill 791.

Utilization review techniques, particularly prior authorization and step therapy, have become significant barriers to patient care, often resulting in delays, denials, and unnecessary administrative burdens for both patients and healthcare providers. The statistics from the 2022 Report on the Maryland Health Care Appeals and Grievances Law are alarming, indicating a substantial increase in adverse decisions by insurance carriers, adversely affecting patient outcomes and adding to healthcare costs.

The proposed legislation addresses several key issues in utilization review, with a focus on streamlining processes, enhancing transparency and communication, and ultimately prioritizing patient care. The provisions outlined in the bill, such as prohibiting denials for medication renewals when previous approval has been granted and ensuring timely communication and explanation of denial decisions, are essential steps towards mitigating the adverse impact of utilization review on patients.

Furthermore, the emphasis on increasing transparency, providing dedicated call lines for denials, and mandating peer-to-peer reviews when requested by healthcare providers are critical measures to foster better communication and collaboration between insurers and healthcare professionals. By aligning review criteria with established medical standards and ensuring that decisions are based on clinical expertise, we can uphold the integrity of the healthcare system and prioritize the needs of our patients.

We are also in strong support of the provision prohibiting an insurer/PBM from issuing an adverse decision on a reauthorization for the same prescription drug or request additional documentation from the prescriber for the reauthorization request if: (i) the entity previously approved a prior authorization for the prescription drug for the insured; (ii) the insured has been treated with the prescription drug without interruption since the initial approval of the prior authorization; and (iii) the prescriber attests that, based on the prescriber's professional judgment, the prescription drug continues to be necessary to effectively treat the insured's condition (page 7, lines 11-22).

Patients are routinely harmed when insurers approve a prescription drug for a year and then take that drug away from the patient – not because the drug isn't effectively managing their symptoms but because the insurer's formulary has changed (often due to rebates), and the patient is now being forced off a drug to take a cheaper drug. This creates a never-ending cycle where the patient is subjected to repeated drug changes based on formulary and savings to the insurers without protection to the patient. Too often, this results in a bad health outcome for the patient. I commend the collaborative efforts of the General Assembly, healthcare practitioners, patient advocacy organizations, and insurance carriers in developing this legislation. It reflects a commitment to addressing the challenges posed by utilization review techniques and striving for a more patient-centered approach to healthcare delivery.

In conclusion, on behalf of MPMA and its members, I urge you to support Senate Bill 791 and advocate for its passage to enact meaningful reforms that will improve patient access to care, enhance transparency and communication in the utilization review process, and ultimately, promote better health outcomes for all Maryland residents.

For these reasons, we respectfully request a favorable report.

Sincerely,

Adam Lowy, D.P.M., President

Cc: Richard Bloch, J.D., Executive Director
Sarah Peters, Lobbyist

2024 Legislation (SB 791- HI - Utilization Review

Uploaded by: State of Maryland

Position: FAV

MARYLAND Health Care Commission

Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

2024 SESSION
POSITION PAPER

BILL NO: **SB 791**

COMMITTEE: **Senate Finance Committee**

POSITION: **Support**

TITLE: **Health Insurance - Utilization Review - Revisions**

BILL ANALYSIS

SB 791 - Health Insurance - Utilization Review – Revisions if passed alters and establishes requirements and prohibitions related to health insurance utilization review; alters requirements related to internal grievance procedures and adverse decision procedures; alters certain reporting requirements on payors relating to adverse decisions; and establishes requirements on payors and health care providers relating to the provision of patient benefit information. The bill requires payors to establish and maintain an online process that links directly to all e-prescribing systems and electronic health record systems using certain national standards;[1] can accept and approve electronic prior authorization requests; and links to real-time patient out-of-pocket costs, including copayment, deductible, and coinsurance costs and more affordable medication alternatives. The Maryland Health Care Commission (MHCC) and Maryland Insurance Administration (MIA) are required to study the development of standards for the implementation of payor programs for prior authorization, including programs that have been implemented or are being considered in other states. A report on study findings and recommendations is due on December 1, 2024, to the General Assembly. The MHCC and MIA must establish a workgroup to assess progress toward implementing the law and review issues or recommendations from other states. A report on findings and recommendations from the workgroup is due on December 1, 2025, to the General Assembly.

POSITION AND RATIONALE

The MHCC supports the aims of SB 791 in reshaping prior authorizations processes for medical services and pharmaceuticals. On January 17, 2024, the Centers for Medicare &

[1] The National Council for Prescriptions Drug Programs (NCPDP) SCRIPT Standard and the NCPDP Real time Benefit Standard.

Medicaid Services (CMS) released the Interoperability and Prior Authorization Final Rule.[2] The Final Rule builds on initiatives by CMS and the Office of the National Coordinator for Health Information Technology to advance data sharing and interoperability of electronic health information to improve care continuity and patient access to information, and prevent information blocking.[3] Electronic prior authorizations help eliminate paper-based forms and manual submissions to accelerate review and decision-making so patients receive timely access to necessary treatments and medications.[4] Efforts to integrate technology and standardize electronic prior authorization processes support real-time status updates and goals of reducing administrative burden on providers.[5]

Electronic preauthorization emerged to streamline communications between providers and payors regarding patient coverage and eligibility and determinations of medical necessity.[6] In 2012, Maryland became one of the first states to enact legislation that required payors and pharmacy benefit managers (PBMs) to implement electronic preauthorization processes in a phased approach, which included a requirement to establish web-based portals.[7, 8] Chapters 534 and 535 (SB 540/HB 470) of the 2012 Laws of Maryland required MHCC to work with payors and PBMs to attain benchmarks for standardizing and automating the preauthorization process for medical services and pharmaceuticals.[9] The MHCC developed supporting regulations, which includes a process for a payor or PBM to be waived from attaining the benchmarks under certain circumstances.

At its core, electronic prior authorizations digitize and automate key steps to facilitate communication between providers and payors. The MHCC endorses the aims of SB 791

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[2] The CMS Final Rule full name is "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program." The CMS Final Rule is available at: www.cms.gov/files/document/cms-0057-f.pdf.

[3] Codified at 45 C.F.R. Part 171.

[4] RTI Health Solutions, *Evaluation Of The Fast Prior Authorization Technology Highway Demonstration*, October 2021. Available at: healthcare.rti.org/insights/evaluation-fast-prior-authorization-technology-highway-demonstration.

[5] National Library of Medicine, *Perceptions of prior authorization by use of electronic prior authorization software: A survey of providers in the United States*, October 2022. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC10332446/.

[6] Altarum Institute, "*Impacts of Prior Authorization on Health Care Costs and Quality*," November 2019. Available at: www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf.

[7] Enactment of the law was informed by an MHCC report based on recommendations from a multi-stakeholder workgroup, *Recommendations for Implementing Electronic Prior Authorizations,* December 2011.

[8] A web-based portal is a standalone system; also referred to as an "online preauthorization system."

[9] Md. Code Ann., Health-Gen. § 19-108.2.

that utilize national standards to streamline administrative processes, foster greater interoperability, reduce administrative burden, and speed up access to necessary treatments and medications. Improving electronic preauthorization supports improvements in care coordination and improves transparency between payors and providers conducting utilization review activities. The MHCC believes the legislation will support efforts to improve the delivery of quality care in a cost effective and timely manner.

The MHCC notes that the bill limit payors from issuing an adverse decision on a reauthorization for the same medication or request additional documentation from the prescriber for the reauthorization. To reassure payors, providers, consumers, and policymakers, the MHCC will monitor the impact of the bill, if enacted, using the Medical Care Data[10] to assess if this new regulatory framework continues to promote access to safe, effective, and affordable prescription medications.

For the stated reasons above, we ask for a favorable report on SB 791.

[10] The Medical Care Data Base, also called the All Payer Claims Data Bases contains medical and pharmacy utilization data for Medicare, Medicaid, the privately insured market

SB 791 - Health Insurance Utilization Review - LOS

Uploaded by: Steven Chen

Position: FAV

Maryland
Hospital Association

February 21, 2024

To: The Honorable Pamela Beidle, Chair, Senate Finance Committee

Re: Letter of Support- Senate Bill 791 - Health Insurance – Utilization Review – Revisions

Dear Chair Beidle:

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 791. Health insurance carriers often require "prior authorization," which is a process where the carriers review in advance whether a patient-requested item or service is medically necessary. While the practice can be useful, improper use of prior authorization delays access to vital health care services, leading to negative health outcomes. MHA supports proposals to reduce unnecessary delays and expedite patient access to critical health care items and services.

Maryland hospitals operate under a unique Global Budget Revenue Model. Under the Model, the Health Services Cost Review Commission sets each hospital's total annual revenue at the beginning of a fiscal year regardless of the number of patients served or the amount of services provided. Maryland hospitals therefore have no incentives to provide unnecessary care since additional patients or procedures would not increase a hospital's total revenue. Thus, prior authorization under GBR is largely formalistic as hospitals are already motivated to provide only necessary services.

Given the unique financial structure of Maryland hospitals, MHA believes that reforms to streamline prior authorization would reduce unnecessary delays to critical health care services. SB 791's proposal to establish time frames that carriers have available to review a prior authorization request, for example, should reduce the delays patients must endure as they wait for carrier approvals. To the extent SB 791 helps improve the authorization process enabling hospitals to discharge patients who no longer need emergency department or acute care services to more appropriate care settings, it would alleviate bottlenecks in hospital throughput. Finally, the bill's proposal to require a study to examine adjustments to prior authorization requirements based on a provider's prior approval rates should also limit unnecessary patient wait time.

For these reasons, we request a ***favorable*** report on SB 791.

For more information, please contact:
Steven Chen, Director, Policy
Schen@mhaonline.org

SB 791 - Support - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FAV

February 20, 2024

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building – 3 East
Annapolis, MD 21401

RE: Support – Senate Bill 791: Health Insurance - Utilization Review - Revisions

Dear Chair Beidle 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/WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS strongly support Senate Bill 791: Health Insurance - Utilization Review - Revisions (SB 791) 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 healthcare savings mechanism, this process 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 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, leading 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 healthcare costs and devastating effects for individuals and their families. This includes recurrence or worsening of psychiatric***

symptoms, withdrawal symptoms, medical complications related to metabolism or blood pressure, relapse, and risk of harm to themselves or others.

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 791 takes just that approach.

SB 791 seeks to accomplish the following:

- **Eliminate prior authorization for reauthorization of the same drug**. Patients responding successfully to psychiatric medication(s) should be able to continue on their medication(s) if their prescriber attests that it is in their patient's best interest.

- **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 when changing health insurance carriers.** The 90-day window provided under SB 791 to health insurance carriers to perform a prior authorization with a new patient, but also allowing that patient to stay on the psychiatric medication that has been helping her is equitable and will foster a seamless transition from one insurance provider to another.

- **Require denials and denial reviews to be conducted within 24 hours for time-sensitive cases.** As detailed above, psychiatric patients who come off their medication experience deteriorating impacts on physical and mental health abruptly. In these time-sensitive matters, it is important that the patient's insurance carrier, who is rendering the denial and creating the delay in treatment, be readily available and responsive to remedy the disruption in care.

- **Peer-to-peer reviews by physicians.** 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. The changes proposed under SB 791 ensure that when a physician seeks a "peer to peer" on a denial review, she receives one with a board certification or eligibility in the same specialty and who is knowledgeable about the requested healthcare service or treatment.

Patients, especially those with mental health and substance use disorders, need timely access to medication. Please support SB 791, 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 791.

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

MOH Support SB 791 Senate Finance 2024 (002).pdf
Uploaded by: Valerie Skvirsky
Position: FAV

Senator Pam Beidle, Chair
Senator Kathy Klausmeier, Vice-Chair
Senate Finance Committee
Miller Senate Office Building
11 Bladen St, Annapolis MD, 21401

MARYLAND ONCOLOGY HEMATOLOGY

February 21, 2024

Support SB 791: Health Insurance – Utilization Review – Revisions

Honorable Chair, Vice Chair, and Members of the Senate Committee,

Thank you for the opportunity to convey our Support for **SB 791: Health Insurance – Utilization Review – Revisions** on behalf of Maryland Oncology Hematology (MOH). Passage of this bill as introduced would make important updates to Maryland's prior authorization statutes that will have a meaningful impact on timely access to appropriate care for the critically ill patients that we treat.

At Maryland Oncology Hematology (MOH), we offer quality cancer care that provides every advantage to help control and cure the disease. Our team of 52 board-certified physicians and numerous advanced practitioners are dedicated to the evaluation and treatment of all types of cancers and blood disorders. Our providers are backed by a team of oncology certified nurses, laboratory technologists, and support staff, with one goal in mind, to provide personal care and support so our patients can focus on healing. With 15 locations across Maryland, we provide convenient and high-quality cancer care to over 77,000 cancer patients a year.

Utilization management processes like prior authorization were originally intended to be a check and balance for uncommon or high-cost procedures; however, it has now become a catchall for restricting access to care. Over the last few years, prior authorization requirements for common cancer treatments and oral oncolytic medications have significantly increased, leading to delays in needed care, interference with the physician-patient relationship, increases in overall health care costs as patients try and fail multiple costly treatment options before qualifying for the most appropriate drug, and most importantly, adverse outcomes for patients.
.

Without guardrails to protect the patient, these protocols would take clinical decision making out of the physician's hands and give it directly to the insurance company. Those at the health plan reviewing the prior authorization requests have no direct knowledge of the patient, insufficient training in the most up to date clinical evidence, and/or lack specialized expertise in cancer care.

With that in mind**, we urge the Senate Committee the pass this legislation with the following provisions preserved** so that patient's intended treatment protocols remain intact:

- **Prohibiting carriers from issuing a denial of care when a patient requests a renewal for a previously approved drug when they have been successfully treated on that drug in the past**. Switching patients from one drug to another in its class can cause patients to lose efficacy in their treatment regimens. Additionally, it has been cited to increase overall costs of care as the loss of efficacy leads to further physician office visits, potential increased dosages or instances of treatment, and hospitalizations.[1]
- **Requiring 90 days of continuity of care in authorized prescription drug coverage** as the patient transitions from one state health plan to the next. This will allow physicians to work with their patient's

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7021884/

health plan to adapt treatment protocols as needed, if needed, in a way that minimizes harm to the patient.

- **Mandating that health care provider requested "peer to peer" reviews must occur between clinicians of the same specialty.** Oncologists treat patients with diverse diseases expressing highly complex presentations. It is critical that peer-to-peer reviews in oncology be performed with clinicians who have background knowledge of malignancies.
- **Deeming carrier approval of prior authorization requests if unacknowledged within a certain timeframe.** Cancer patients' outcomes are highly dependent on the timeliness of access to care. By placing definitive guardrails around how long a health plan may deliberate on prior authorization, care delays can be diminished.
- **Studying the possible elimination of prior authorization through "Gold Carding" programs and "Value Based Care" arrangements**. The process of applying for prior authorization is a tremendous administrative burden on physician practices and causes an overwhelming care delay for patients. We support any endeavor to find a thoughtful, evidence-based approach to reduce this delay and burden.

Since we are treating so many individuals in our communities, our practice has a full team dedicated to processing prior authorization requests to ensure that our patients receive the most appropriate care. We accept every health plan offered in the state, offer a full range of charitable care options, and work with every patient to help meet their needs. The improvements to utilization management processes in state-based health plans that this bill has put forward will have a marked impact on our team's ability to process these administrative requests in a timely manner. It will lead to more improved outcomes for the 1 in 5 of our patients who are on state-based health plans by offering them reduced care delays, higher quality clinical supports, and more continuity in their access to medications.

This bill could be a game changer for the thousands of Maryland patients who rely on us every year for quality cancer care. If you have any further questions regarding the impact of prior authorization on cancer patients, please do not hesitate to reach out. We welcome the opportunity to be a further resource for you. Thank you for your time and we hope that you will consider joining us in our support for this measure.

Sincerely,

George Sotos, MD
Practice President
Maryland Oncology Hematology

Legal Action Center Testimony SB791_Health Insuran
Uploaded by: Ellen Weber
Position: FWA

LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

Health Insurance – Utilization Review – Revisions (SB 791)
Senate Finance Committee
February 21, 2024
FAVORABLE WITH AMENDMENTS

Thank you for the opportunity to submit testimony in favor of SB 791 with amendments which, among other revisions, would require private review agents to use uniform utilization review standards in making medical necessity determinations for all medical conditions including mental health and substance use disorders. This testimony is submitted by the Legal Action Center, a law and policy organization that has worked for 50 years to fight discrimination, build health equity and restore opportunities for individuals with substance use disorders, arrest and conviction records, and HIV and AIDs. In Maryland, we convene the Maryland Parity Coalition and work with our partners to ensure non-discriminatory access to mental health and substance use disorder services through enforcement of the federal Mental Health Parity and Addiction Equity Act (Parity Act) in both public and private insurance. Utilization review (UR) standards are at the core of whether Marylanders get access to the care they need and pay for through their insurance plan, and those standards must comply with the Parity Act.

We support SB 791 to ensure that private review agents (PRA) (1) use the right medical necessity standards when making authorization and payment decisions for mental health (MH) and substance use disorder (SUD) treatment and (2) provide more detailed information about the basis for adverse decisions. We urge the Committee to adopt two amendments that would apply to authorization decisions for MH and SUD care, as proposed in SB 93: requiring PRAs to make level of care determinations based on the patient's underlying chronic condition and requiring PRAs to explain the criteria it believes the patient has not satisfied prior to issuing a denial.

1. **Mandatory Use of Evidence-Based Medical Necessity Standards Developed by Professional Medical and Clinical Societies.**

SB 791 would require private review agents to use the medical necessity and level of care standards that have been developed by the non-profit medical and clinical specialty society for the relevant medical condition, unless a professional society does not have criteria for a specific condition. The proposed standard is consistent with the American Medical Association's Prior Authorization and Utilization Management Reform Principles, which recommends that UR entities "standardize criteria across the industry to promote uniformity and reduce administrative burden." (Principle #18). As the AMA explained, the lack of standardization and extensive use of proprietary forms imposes significant administrative burden on providers. For purposes of patient care, "any clinically based utilization management criteria should be similar – if not identical – across utilization review entities."

Maryland has required the use of standardized evidence-based UR standards for SUD care – the American Society of Addiction Medicine (ASAM) Criteria since 2019 Ins. § 15-802(d)(5). SB 791 would extend the same statutory protection to MH care, benefitting both consumers and providers. Regardless of a consumer's insurance plan, access to care would be based on standardized professional care guidelines that address the patient's full medical condition and psychosocial needs. A patient and their practitioner will have greater control over their health care because the UR criteria will be developed by a professional medical society that has no financial stake in the authorization of patient care. Receiving the right level of care at the initiation of treatment

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facilitates recovery and reduces the likelihood that the individual will cycle needlessly through more costly episodes of care.

Equally important, providers will spend less time challenging denials that have been based on proprietary standards that are inconsistent with professional society standards. We know that some MH providers do not participate in carrier networks because the administrative burden associated with addressing denials of patient care is far too onerous. The proposed UR standard, if implemented with fidelity, will, over time, improve patient care and practitioner participation in networks.

2. Two Additional UR Protections Will Ensure Access to the Right Level of Care for Individuals with Mental Health and Substance Use Disorders.

We urge the Committee to adopt two requirements, set out in SB 93, that would address unique barriers to more intensive levels of MH and SUD care. **First, PRAs must authorize treatment to address the patient's underlying chronic condition rather than make care determinations based on the patient's acute symptoms alone.** Like many medical conditions, an individual with a MH or SUD may present both acute symptoms (e.g. an overdose, psychotic episode, suicidal ideation) and an underlying condition (e.g. major depression, an alcohol or opioid use disorder), both of which must be treated through a range of services of varying degrees of intensity and/or medications. Health plans commonly deny authorization for medically necessary subacute care that is required for the treatment of the patient's chronic MH or SUD by using UR standards that require on-going acute symptoms. While the use of the professional society UR will begin to address this problem, the PRAs must also implement those standards with fidelity. Essentially, a PRA should not selectively apply the criteria in a way that prevents the patient from getting the care they need to recover – such as covering treatment for their withdrawal management from the substance but denying ongoing care at the appropriate to address the underlying SUD. To prevent this misapplication or selective application of the "right" criteria, we urge the Committee to require the PRA to make all decisions consistent with the required criteria for chronic care treatment and not limit treatment to services for acute care.

We also urge the Committee to adopt a second safeguard against erroneous denials of MH and SUD care by requiring the PRA to explain to the treating provider the specific criteria a patient does not meet ***before issuing the denial*** to allow for immediate corrective action. While SB 791 would appropriately require PRAs to provide more detailed information in their denial notices, a pre-denial explanation is important for MH and SUD care because Marylanders rarely challenge those adverse decisions. Only **one-half of one percent (0.59%)** of MH and SUD adverse decisions are challenged in a grievance process – a much lower rate than for other medical adverse decisions – even though **one-third (37%) of challenged decisions are overturned by the carrier.** Office of Attorney General, Health Education and Advocacy Unit, Annual Report on the Health Insurance Carrier Appeals and Grievances Process for FY 2023. Clearly many Marylanders who do not challenge their adverse decision are being denied insurance coverage to which they are entitled and need. The proposed amendment would reduce the burden on both patients who do not have the support or capacity to challenge an adverse decision as well as practitioners who must spend significant time engaging in post-denial discussions.

Thank you for considering our views. We urge the Committee to issue a favorable report with amendments on SB 791.

Ellen M. Weber, J.D.
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SB791.LOSWA.hf.20240220.pdf
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February 20, 2024

TO: Pamela Beidle
Chair, Senate Finance Committee

FROM: Health Education and Advocacy Unit

RE: SB0791 – Health Insurance –Utilization Review – Revisions
Support with Amendments

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports the goal of eliminating unnecessarily strict utilization review protocols used by carriers to deny claims for medical treatment appropriately prescribed for patient care. The changes this bill proposes should help eliminate delays in care, reduce inappropriate denials of medically necessary care, and reduce administrative costs for health care providers.

Insurers will frequently point to utilization review protocols as key to controlling health care costs, but overly stringent policies not only prevent patients from obtaining the necessary care recommended by their health care providers, but any short-term savings get shifted downstream as unnecessary administrative costs to other parts of the health care system, through delays in patient care and resulting complications, and increased administrative burdens to providers.

The HEAU assists consumers in mediating and filing a grievance or appeal of carrier denials of claims, and in FY23 nearly 60% of the cases the HEAU mediated, denial decisions were overturned or modified. Similarly, when the Maryland Insurance Administration (MIA) investigated complaints in FY23, the carrier's decision was modified or reversed by the MIA, or by the carrier during the MIA's investigation, in nearly 70% of cases. Notably, the MIA-reported data showed that 43% of the grievances filed were pharmacy/formulary related cases; 81% were

overturned by the MIA or reversed by the carrier once challenged. Eleven percent of the appeals and grievances cases the HEAU mediated were pharmacy related; 68% of the denials were overturned or modified. (For more data details, please see HEAU's Annual Reports, https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/annualreports.aspx.)

While this reflects positive outcomes for consumers who obtain assistance, it also suggests that carriers are inappropriately denying claims, causing significant financial and emotional burdens for consumers.

The following are just a few examples of the HEAU cases in which consumers were burdened by overly restrictive utilization review protocols:

1. A claim for a Positron Emission Tomography (PET) scan for a 16-year-old girl with epithelioid hemangioendothelioma (EHE), a rare type of vascular cancer that affects the lining of the blood vessels, was denied by the carrier as not "medically necessary." She had also recently been diagnosed with uveitis (a form of eye inflammation), another rare condition, and her medical team was unsure whether a link existed to her EHE. A previous PET scan had shown active lymph nodes, and the subsequent scan was sought to guide future biopsies and to determine if the uveitis was a result of active EHE or another malignancy, essential to determining her treatment plan. The carrier denied reimbursement in the first instance and during the internal appeal process, but when the HEAU submitted a second-level internal appeal, the denial was overturned.

2. A 53-year-old woman was referred to a neurologist after experiencing a transient ischemic attack (TIA or "mini-stroke"). She also had a history of complex migraines. She had tried various medications for treatment of her migraines with no improvement, and in one instance experienced a severe reaction. The neurologist provided her with a branded medication with no generic available (physician samples) and the patient experienced significant improvement. However, when the neurologist tried to get the medication pre-authorized for maintenance, it was denied by the patient's plan's Pharmacy Benefit Manager ("PBM") for not meeting Step Therapy protocols. The HEAU successfully appealed to the PBM for an exception because step therapies had already been tried and failed. The PBM overturned the denial and authorized coverage of the prescription, saving the patient $980/per month in out-of-pocket costs. It took nearly five months from the time the provider initially prescribed the medication until it was approved.

3. A consumer wrote to the HEAU because his health insurance would not authorize an MRI on his lower back. His provider needed the MRI to determine whether surgery, pain management, or some other intervention would be the best course of treatment. The consumer was in excruciating pain but as a recovering drug addict he was committed to getting through each day

without falling back into the abyss of drugs. He was frequently in tears of pain and frustration. The carrier insisted a long list of requirements had to be met before the MRI could be approved. The HEAU was able to compile enough information and records to convince the carrier to approve the MRI during the internal appeal process.

4. 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.

These stories are not unique and highlight the frequent problems faced by both consumers and providers. The data shows that denials of coverage are overturned or modified at a high rate, so the current process only prevents or delays access to timely and appropriate care, jeopardizing patient health and well-being and burdening healthcare providers.

The HEAU appreciated the opportunity to participate in the many workgroup meetings that occurred during the interim and appreciates the work of the many stakeholders who engaged in these meetings. The final draft is largely reflective of that work. But the HEAU does have some minor, largely technical, concerns about the bill and other recommendations which we've shared with the advocates. We look forward to working with all stakeholders to strengthen protections without inadvertently reducing or hindering consumer rights under existing law, and thank the Committee for a favorable report on SB 791.

Suggested Amendments and Recommendations

1. On page 9, lines 18-20 and page 21, lines 6-8. It has long been the HEAU and the MIA's position that a carrier's denial of coverage based on a prior authorization or step therapy is an adverse decision subject to the appeals and grievances process under Title 15, Subtitle 10A, but don't object to this being specifically enumerated in the statue to the extent it reduces arguments to the contrary.

2. On page 12, lines 9-23. We support a requirement that carriers must initiate the expedited procedure in an emergency case with a provider attestation supporting the emergency, but we want to ensure that carriers also provide that expedited procedure even in the absence of a provider attestation, when warranted. We sometimes help consumers who come to us directly and the provider has not had time to get involved. Some cases are self-evident based on the supporting medical records. Accordingly, we request the following amendment:

   On page 12, line 13, after "THE HEALTH CARE PROVIDER ATTESTS" strike "THAT" and INSERT ", OR THE INFORMATION OTHERWISE INDICATES THAT"

3. On page 12, lines 9-23. We do not object to including the definition of an emergency case in the statute, but we believe the Commissioner should retain the ability to add additional criteria without the need for a statutory change should the need become necessary. Accordingly, we request the following amendments:

   On page 12, at the end of line 21, strike "OR"

   On page 12, at the end of line 23, replace the "." With a ";" and INSERT " 4. OR MEET ANY OTHER STANDARD THE COMMISSIONER DEFINES BY REGULATION."

4. On page 12, line 19 and page 27, line 13. We suggest an amendment to make this language consistent with current language in EMTALA and the No Surprises Act.

   On page 12, line 19 and page 27, line 13, after the first "member" INSERT "OR A PREGNANT MEMBER'S UNBORN CHILD"

5. On page 14, line 3 and page 16, line 9. We are concerned that the use of the term medically necessary is too limiting and not consistent with the remainder of the statute. "*See* definition of adverse decision, Ins. 15-10A-01. Accordingly, we request the following amendment.

   On page 14, line 3 and on page 16, line 9, after "MEDICALLY NECESSARY" INSERT "APPROPRIATE, OR EFFICIENT"

2024 SB791 Opposition or Amend.pdf
Uploaded by: Deborah Brocato
Position: UNF

Opposition Statement SB791
Health Insurance – Utilization Review - Revisions
Deborah Brocato, Legislative Consultant
Maryland Right to Life

Maryland Right to Life strongly objects to SB791 as we continue to oppose the appropriation and use of any public funds for the purposes of abortion. Altering reporting requirements provides liability shields for healthcare providers and prohibits patients from the ability to seek recompense. We oppose the use of this bill to promote and fund organizations that promote and provide abortion services. We also oppose the use of this bill to adversely affect healthcare professionals and healthcare organizations that do not promote or provide abortion services due to conscientious objections. We request an amendment to exclude abortion purposes from this bill. Without it, we ask for an unfavorable report on SB791.

The bill allows for "acceptance of electronic prior authorization requests" without requiring "additional information" or "clinical review." The bill will provide a process by which "a health care provider may request and receive a waiver of compliance" with maintaining health records of "an insured or enrollee." These and other changes to how healthcare providers operate are not in the best interest of patients, and, specifically, when it comes to women and girls who consume abortion pills. Repeated use of abortion pills only increases the likelihood of adverse reactions to the abortion pills up to and including death.

ABORTION IS NOT MEDICALLY NECESSARY. Pregnancy is not a disease and 95% of biologists agree that a unique human life begins at the moment of fertilization. Abortion is not healthcare as evidenced by the fact that 85% of obstetricians and gynecologists in a national survey refuse to participate in abortion practices. Medical intervention necessary to save the life of the mother, including for ectopic pregnancy and miscarriage, is not prohibited by the law of this or any other state.

The state of Maryland has no legal obligation, nor moral authority to use public funds for abortion or to be a sponsor of the abortion industry.

The Supreme Court of the United States, in *Dobbs v. Jackson Women's Health* (June 24, 2022), overturned *Roe v. Wade* (1973) and held that there is no right to abortion found in the Constitution of the United States. As early as 1980 the Supreme Court affirmed in *Harris v. McRae*, that *Roe* had created **a limitation on government, not a government funding entitlement**. The Court ruled that the government may distinguish between abortion and other

procedures in funding decisions -- noting that "*no other procedure involves the purposeful termination of a potential life*", and held that there is "*no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds*."

Despite the fact that the Maryland General Assembly enacted a liberal abortion statute in 1991, the Maryland General Assembly moved to further promote abortion with the *Abortion Care Access Act* of 2022. Now, the removal of the physician requirement leaves women and girls with a higher risk of adverse events up to and including death at the hands of a "qualified provider," with unspecified training from the state of Maryland. Because Medicaid and private health insurance are required to fully fund abortion, Maryland taxpayers pay for abortion.

ABORTION IS UNSAFE IN MARYLAND. Despite the Supreme Court ruling, abortion remains legal through all nine months of pregnancy and for any reason, under the *Maryland Freedom of Choice Act* (1991). The state of Maryland has repealed all criminal penalties and statutory restrictions on abortionists and abortion practices. Regulations on abortion clinics and practices are not routinely enforced. Physicians now serve only a tangential role on paper *if at all*, either as remote medical directors for abortion clinics or as remote prescribers of abortion pills.

As a result of these pernicious policies, the practice of abortion in Maryland has become the "red light district" of medicine, populated by dangerous, substandard providers. Through the *Abortion Care Access Act* of 2022, the state is depriving poor women access to care by a licensed physician. Through "telabortion" and the unregulated proliferation of "Do-It-Yourself" chemical abortion pills, the abortion industry itself has exposed women to "back alley" style abortions, where they bleed alone without medical supervision or assistance, then flush their babies down toilets. This is not progressive, but regressive.

MDH IS FAILING PREGNANT WOMEN AND FAMILIES. The Maryland Department of Health has consistently failed to meet the needs of pregnant women and families in Maryland and any appropriation should be withheld until the Department provides the annual report to the Centers for Disease Control to measure the number of abortions committed each year in Maryland, abortion reasons, funding sources and related health complications or injuries.

- The Department has routinely failed to enforce existing state health and safety regulations of abortion clinics, even after two women were near fatally injured in botched abortions.
- The Department has routinely failed to provide women with information and access to abortion alternatives, including the Maryland Safe Haven Program (Department of

Human Services), affordable adoption programs or referral to quality prenatal care and family planning services that do not promote abortion.

- The Department has demonstrated systemic bias in favor of abortion providers, engaging in active partnerships with Planned Parenthood and other abortion organizations to develop and implement public programs, curriculum and training. In doing so the Department is failing to provide medically accurate information on pregnancy and abortion.
- The Department systemically discriminates against any reproductive health and educational providers who are unwilling to promote abortion and in doing so, suppresses pro-life speech and action in community-based programs and public education.
- The Department fails to collect, aggregate and report data about abortion and the correlation between abortion and maternal mortality, maternal injury, subsequent pre-term birth, miscarriage and infertility.
- The Department is failing to protect the Constitutionally-guaranteed rights of freedom of conscience and religion for health care workers, contributing to the scarcity of medical professions and personnel in Maryland.
- The Department is failing to protect women and girls from sexual abuse and sex trafficking by waiving annual reporting requirements for abortionists, waiving mandatory reporter requirements for abortionists, and failing to regulate abortion practices.

ABORTION IS LEADING KILLER OF BLACK LIVES. Abortion has reached epidemic proportions among people of color with half of all pregnancies of Black women ending in abortion. The Black population has long been targeted for elimination through sterilization and abortion. Even today, 78% of abortion clinics are located in minority communities. As a result abortion has become the leading killer of Black lives. Abortion is the greatest human and civil rights abuse of our time and as a civilized people we cannot continue to justify or subsidize this genocide.

ABORTION IS A FAILED POLICY. 50 years of legal abortion never ended childhood poverty, rape and incest or unplanned pregnancies. In fact, the amount of abortions has increased proportionately to the increase in public funding for abortion. The abortion industry is financially invested in unplanned pregnancy and cannot be entrusted to provide for the reproductive health needs of Maryland women and families.

For these reasons, we respectfully urge you to amend SB791 to exclude abortion purposes. Without the amendment, we request an unfavorable report on SB791.

SB791 Written Statement 2.21.2024.pdf
Uploaded by: Laura Vykol-Gray
Position: INFO

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HELENE GRADY
Secretary

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SENATE BILL 791 Health Insurance - Utilization Review - Revisions

STATEMENT OF INFORMATION

DATE: February 21, 2024

COMMITTEE: Finance

SUMMARY OF BILL: Senate Bill 791 seeks to alter and establish requirements and prohibitions related to the utilization review process. These changes would be applicable to insurers or nonprofit health service plans, health maintenance organizations and pharmacy benefit managers (PBMs).

EXPLANATION: The Secretary of Budget and Management (DBM) has broad authority for administration of the State Employee and Retiree Health and Welfare Benefits Program (the Program) and responsibility for ensuring the Program complies with all federal and State laws governing employee benefit plans, under State Personnel & Pensions Article, Section 2-502, 2-503. DBM's Office of Personnel Services and Benefits, Employee Benefits Division, administers the medical and prescription drug benefits coverage for State employees, retirees, and their dependents.

The changes proposed by Senate Bill 791 will result in significant costs for the State's prescription drug plan. The State currently contracts with a PBM to manage the prescription drug plan for State employees and retirees. The State's PBM employs utilization management and prior authorization to reduce unnecessary costs while ensuring the State's membership receives appropriate coverage. Senate Bill 791 proposes to alter requirements for prior authorizations, adverse determinations, transition of care timelines, and course of treatment, which would impact the State's ability to apply appropriate utilization management in the Program. Changes to prior authorizations are estimated to increase costs by more than $60 million annually and reduce rebates by $31 million, for a total annual impact of $91 million. It would be challenging for the State to take on these additional costs. Premium increases shared between the State and employees/retirees would likely be necessary.

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