Maryland Community Health System

Committee: **House Health and Government Operations Committee**

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

Hearing Date: **March 28, 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 as long as the drug is for mental health or a biologic if used for immunotherapy: (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