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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"