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SB791 Health Insurance - Utilization Review – Revisions
House Health and Government Operations Committee
FAVORABLE
March 28, 2024

Good afternoon, Chair Pena-Melnyk and members of the House Health and Government Operations 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. This important bill, aided by the clarifying amendments added since it was originally heard this session, will reduce or eliminate many of the biggest problems and 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 being 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.

The amendments made to the bill since it originally was heard add clarity and completeness to the legislation by accounting for such important and time-sensitive situations as biological prescription drugs used for immunotherapy or treatment of mental disorders. They also broaden the availability of expedited procedures to include situations brought to the review agent's attention by the patient or the patient's representative.

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.