MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq, Chairman
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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