SB475 - VBC - Hopkins - SWA.pdf
Uploaded by: Annie Coble
Position: FAV

JOHNS HOPKINS
UNIVERSITY & MEDICINE

TO: The Honorable Pamela Beidle, Chair
Senate Finance Committee

SB475
Support with Amendments

FROM: Annie Coble
Assistant Director, Maryland Government Affairs

DATE: February 12, 2025

RE: SB475: Health Insurance - Utilization Review - Exemption for Participation in Value- Based Care Arrangements

Johns Hopkins would like to offer its support for **SB475: Health Insurance - Utilization Review - Exemption for Participation in Value- Based Care Arrangements** and request an amendment for how to ensure easy implementation**.** This bill prohibits certain insurance requirements for health care services in two-sided incentive arrangements. The goal of legislation is commendable, to ease administrative burden on providers. Value-Based Care Arrangements are specially agreed upon contracts with providers and payers, the nuances of these agreements and mechanisms for implementation need to be considered when implementing policy changes proposed in this legislation.

Currently, Johns Hopkins Medicine participates in several value-based care arrangements with a variety of public and private payors. We believe these arrangements have improved the quality and value of our patient care. These arrangements are often focused on specific quality metrics alongside cost and utilization targets. Other components – including medical necessity review, cost control mechanisms, and workflow processes may exist today outside of these arrangements. We would want to ensure any changes would be complimentary to our current arrangements and processes.

As the Committee is considering this legislation, we would ask for clarification regarding the attribution methodology for these arrangements to ensure there is clarity on those populations that are excluded from any cost control or authorization requirements. To the extent possible, Johns Hopkins would like the attribution methodology to be prospective and to apply across a shared population rather than to specific subgroups to facilitate creation of internal utilization management processes where appropriate.

Johns Hopkins Medicine manages millions of visits annually and understands the value of alleviating the administrative burden that comes with working with payers. However, as stated, this is a nuanced system and we want to make sure the current processes that are working well for our providers and patients are not disrupted and that we continue to deliver the highest quality and value of care which our patients deserve.

Johns Hopkins urges a favorable with amendments report on **SB475.**

2025 MCA SB 474 Adverse Decisions SUPPORT.pdf
Uploaded by: Ashlie Bagwell
Position: FAV

MARYLAND CHIROPRACTIC ASSOCIATION

Testimony on behalf of the Maryland Chiropractic Association
Senate Bill 474—Health Insurance—Adverse Decisions—Reporting and Examinations
Support
February 12, 2025
Senate Finance Committee

The Maryland Chiropractic Association (MCA) is a professional organization founded in 1928 and is the leading voice for chiropractors in Maryland. Comprised of individual members, our mission is to elevate the chiropractic profession by educating the public and advancing chiropractic care for the citizens of Maryland. We have weighed in on many issues concerning patient care, insurance and other issues of importance to our members as well as our patients and the general public.

On behalf of the Maryland Chiropractic Association (MCA), representing chiropractic professionals across the state, we write to express our strong support for Senate Bill 474, introduced by Senator Beidle. This bill directly addresses a growing concern in healthcare: the increasing frequency of adverse decisions made by health insurance carriers and the need for greater oversight of their decision-making processes.

Chiropractors across Maryland have recently experienced a significant uptick in adverse decisions related to essential and medically necessary services. We believe this increase is largely due to the rapid adoption of artificial intelligence (AI) in the utilization management/utilization review (UMUR) systems used by health plans. While we understand and support the need for responsible UMUR practices to ensure cost-effective, appropriate care, we are increasingly concerned that AI-driven systems may be making decisions improperly or without sufficient human oversight.

By requiring carriers to report significant increases in adverse decisions and provide explanations for the causes—including changes in medical management or AI-related decision-making—Senate Bill 474 will play a critical role in improving transparency and holding carriers accountable.

We appreciate the opportunity to provide written comments on this bill and appreciate Chair Beidle's leadership on this issue.

SB0475_FAV_MedChi, MDAFP, MDAAP, MACHC_HI - Utiliz
Uploaded by: Danna Kauffman
Position: FAV

Senate Finance Committee
February 12, 2025
Senate Bill 475 – *Health Insurance – Utilization Review – Exemption for Participation in Value-Based Care Arrangements*
POSITION: SUPPORT

On behalf of MedChi, The Maryland State Medical Society, the Maryland Academy of Family Physicians, the Maryland Chapter of the American Academy of Pediatrics, and the Mid-Atlantic Association of Community Health Centers, we submit this letter of support for Senate Bill 475. This bill prohibits health insurance carriers from imposing a prior authorization, step therapy, or quantity limit requirement on providers for health care services included in a two-sided incentive arrangement.

In 2022, *Senate Bill 834: Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization* authorized a health insurance carrier to enter a "two-sided incentive arrangement" with an "eligible provider." A "two-sided incentive arrangement" is an arrangement between an eligible provider and a carrier in which the provider may earn an incentive, and a carrier may recoup funds from the provider in accordance with the terms of a contract, essentially creating a situation where the provider accepts the risk of the insurance carrier. Each year, the Maryland Health Care Commission must collect data and report on alternative payment models, like two-sided incentive arrangements.

In its recent report, the Commission pointed out that 47 alternative payment models existed in 2022, nineteen for care episodes. Of those, eight of the 19 arrangements put providers at risk for the recoupment of funds under a two-sided incentive arrangement. In 2021, the American Medical Association conducted a study in 2021 and found that 40% of physicians have staff who work exclusively on prior authorization requests. The survey also found that, on average, almost two business days a week are spent completing prior authorizations. This is both time and money that should be spent on patient care.

Therefore, to make two-sided incentive arrangements more attractive for providers, Senate Bill 475 would exempt providers from managing the prior authorization, step therapy, and quantity limit policies of the insurance carriers—processes that take time and money for providers to complete. Given that providers are at risk for recoupment of funds if costs exceed the expected amount, providers should not be subject to these additional requirements. We urge a favorable vote.

For more information, call:
Danna L. Kauffman
J. Steven Wise
Andrew G. Vetter
Christine K. Krone
410-244-7000

APTA MD 2025 Testimony - Support - Senate Bill 475

Uploaded by: JD Sheppard

Position: FAV

APTA Maryland

Our Vision
Transforming the diverse communities in Maryland to advance health and wellness by optimizing movement and function across the lifespan.

February 12, 2025

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

RE: Senate Bill 475 - Health Insurance - Utilization Review - Exemption for Participation in Value-Based Care Arrangements
Position: SUPPORT

Dear Chair Beidle,

The American Physical Therapy Association Maryland is writing to register our strong support of **Senate Bill 475**. This bill will prohibit *"certain carriers from imposing a prior authorization, step therapy, or quantity limit requirement on eligible providers for health care services that are included in a two-sided incentive arrangement."*

Medicare and commercial payers continue the move toward value-based payment, shifting from payment solely based on the volume of care, such as traditional fee-for-service, to payment more closely related to outcomes of care. Value-based payment models use measures of quality and cost to determine payment for providers. Ensuring high quality of care while controlling cost is key to success in these models. Physical therapists must use standardized quality measures to articulate the value they bring to the health care system, as the shift toward payment that is dependent upon quality-measure performance continues.

Given the design of value-based models and the close interaction between Patient – Provider – Insurer it makes sense to all involved to avoid the administrative burdens that accompany utilization review criteria.

For the reasons noted above we ask for a favorable report on Senate Bill 475.

Sincerely,

Roy Film

Roy Film, PT, DPT, MPT
President, APTA Maryland

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

APTA Maryland
A Chapter of the American Physical Therapy Association

SB475 VBC Testimony.pdf
Uploaded by: Pamela Beidle
Position: FAV

PAMELA G. BEIDLE
Legislative District 32
Anne Arundel County

Chair, Finance Committee
Executive Nominations Committee

Joint Committee on Gaming Oversight
Joint Committee on Management of Public Funds
Spending Affordability Committee

Miller Senate Office Building
11 Bladen Street, Suite 3 East
Annapolis, Maryland 21401
410-841-3593 · 301-858-3593
800-492-7122 *Ext.* 3593
Pamela.Beidle@senate.state.md.us

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

February 12, 2025

Senate Bill 475
Health Insurance – Utilization Review
Exemption for Participation in Value-Based Care Arrangements

Thank you for the opportunity to present Senate Bill 475, Health Insurance—Utilization Review—Exemption for Participation in Value-Based Care Arrangements.

You will recall that, in 2022, we passed *Senate Bill 834: Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments – Authorization*. Before the passage of this bill, carriers and providers were not allowed to enter into value-based arrangements when the provider was at risk for the recoupment of funds if costs were higher than expected. Senate Bill 834 allowed it but put necessary and reasonable parameters on the arrangements.

Given the cost of health care, value-based care delivery is seen as a way to increase quality and decrease costs. However, the uptick of these arrangements has been slow. To incentivize providers to consider and enter these arrangements, SB 475 would prohibit health insurance carriers from imposing a prior authorization, step therapy, or quantity limit requirement on providers for health care services included in a two-sided incentive arrangement.

Last year, during the hearings on the prior authorization legislation, we heard that physicians had to hire additional staff to process all the prior authorizations required by insurance companies and that almost two full days were dedicated to completing these requests.

Prohibiting these utilization management policies from being part of these arrangements will hopefully incentivize more providers to enter into them, given the cost savings that may be associated with the prohibition.

I urge a favorable vote on Senate Bill 475.

Senate Bill 475
Health Insurance – Utilization Review
Exemption for Participation in Value-Based Care Arrangements

Thank you for the opportunity to present Senate Bill 475, Health Insurance—Utilization Review—Exemption for Participation in Value-Based Care Arrangements.

You will recall that, in 2022, we passed *Senate Bill 834: Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments – Authorization*. Before the passage of this bill, carriers and providers were not allowed to enter into value-based arrangements when the provider was at risk for the recoupment of funds if costs were higher than expected. Senate Bill 834 allowed it but put necessary and reasonable parameters on the arrangements.

Given the cost of health care, value-based care delivery is seen as a way to increase quality and decrease costs. However, the uptick of these arrangements has been slow. To incentivize providers to consider and enter these arrangements, SB 475 would prohibit health insurance carriers from imposing a prior authorization, step therapy, or quantity limit requirement on providers for health care services included in a two-sided incentive arrangement.

Last year, during the hearings on the prior authorization legislation, we heard that physicians had to hire additional staff to process all the prior authorizations required by insurance companies and that almost two full days were dedicated to completing these requests.

Prohibiting these utilization management policies from being part of these arrangements will hopefully incentivize more providers to enter into them, given the cost savings that may be associated with the prohibition.

I urge a favorable vote on Senate Bill 475.

Testimony in support of SB0475 -Health Insurance -
Uploaded by: Richard KAP Kaplowitz
Position: FAV

SB0475_RichardKaplowitz_FAV

02/12/2025
Richard Keith Kaplowitz
Frederick, MD 21703

TESTIMONY ON SB#/0475 - POSITION: FAVORABLE

Health Insurance - Utilization Review - Exemption for Participation in Value-Based Care Arrangements

TO: Chair Beidle, Vice Chair Hayes and members of the Finance Committee
FROM: Richard Keith Kaplowitz

My name is Richard Keith Kaplowitz. I am a resident of District 3. I am submitting this testimony in support of SB#/0475, Health Insurance - Utilization Review - Exemption for Participation in Value-Based Care Arrangements

This bill will fix many of the problems in our health care insurance coverage. For example, I have a Medicare Advantage plan. When I went in 2022 to get my right knee totally replaced the doctor and I wanted me to stay in the hospital for 3 days and then transfer to a rehabilitation care facility for the ten days that standard Medicare covers. This was determined to be in my best interests as my wife is mobility challenged and taking care of me would be difficult for us both. My doctor and I, despite multiple appeals, were unable to get authorization for this. My knee surgery was to be done as an outpatient surgery. The only reason I stayed overnight was physical therapy reported I was not ready for discharge. After 28 hours in the hospital, I was discharged and the next two weeks at home were hell on both my wife and me.

This bill says that if you pay premiums your insurance carrier is there to cover your medical care and should stop the high level of denials occurring in our health care system.

> A Commonwealth Fund report published Aug. 1, 2024 examines how frequently insured, working-age adults are denied care by insurers; how often they are billed for services they believed were covered; and their experiences challenging such bills or care denials. The report shows that 45% of insured working-age adults reported receiving a medical bill or being charged a copayment in the past year for a service they thought should have been free or covered by their insurance. Among other findings, 17% of respondents said that their insurer denied coverage for care that was recommended by their doctor, and nearly six of 10 adults who experienced a coverage denial said their care was delayed as a result. [1]

The bill's purpose is to prohibit certain carriers from imposing prior authorization, step therapy, or quantity limit requirement on eligible providers for health care services that are included in a two-sided incentive arrangement. My personal experience and statistics on medical care denials make this a vital change that Maryland should force health care insurers in Maryland to implement.

I respectfully urge this committee to return a favorable report on SB#/0475

[1] https://www.aha.org/news/headline/2024-08-01-report-highlights-unforeseen-health-care-bills-and-coverage-denials-commercial-insurers

SB 475.pdf
Uploaded by: Taylor Dickerson
Position: FAV

MARYLAND
PSYCHOLOGICAL ASSOCIATION

PO Box 368 Laurel, MD 20725 410-992-4258 www.marylandpsychology.org

February 10, 2025

Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice Chair
Finance Committee
Miller Senate Office Building, 3 East
Annapolis, MD 21401

RE: SB475 Health Insurance – Utilization Review – Exemption for Participating in Value-Based Care Arrangements

Position: SUPPORT

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

The Maryland Psychological Association, (MPA), which represents over 1,000 doctoral level psychologists throughout the state, asks the Senate Finance Committee to **FAVORABLY report on SB 475.**

We are writing to ask for a Favorable report on SB 475 which would prohibit prior authorization, step therapy, or quantity limit requirements on providers engaged in two-sided incentive arrangements with health care companies. This legislation is critical in empowering healthcare providers to deliver timely and personalized care without unnecessary administrative barriers which would only benefit the insurance company and limit the practitioner's ability to exercise their clinical judgement. Two-sided incentive arrangements align the interests of providers and insurers towards achieving high-quality, cost-effective patient outcomes. By removing restrictive requirements, this bill will enhance clinical autonomy, reduce delays in patient care, and promote innovative treatment approaches that benefit both patients and the healthcare system. Supporting this legislation will foster a more efficient and patient-centered healthcare environment in our state.

We urge the Committee to issue a **favorable report on SB 475**. If we can be of any further assistance, please do not hesitate to contact MPA's Legislative Chair, Dr. Stephanie Wolf, JD, Ph.D. at mpalegislativecommittee@gmail.com.

Respectfully submitted,

David Goode-Cross, Ph.D.
David Goode-Cross, Ph.D.
President

Stephanie Wolf, JD, Ph.D.
Stephanie Wolf, JD, Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

SB 475 Health Insurance - Utilization Review - Exe

Uploaded by: Jake Whitaker

Position: FWA

Maryland
Hospital Association

Senate Bill 475- Health Insurance - Utilization Review - Exemption for Participation in Value-Based Care Arrangements

Position: ***Support with Amendments***
February 12, 2025
Senate Finance Committee

MHA Position

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 475. SB 475 would prohibit value-based care arrangements, including for Medicare Advantage plans, from imposing step therapy, prior authorization, or quantity limit requirements. This bill will eliminate barriers to care and increase access to critical health services and prescription drugs.

Value-based care arrangements, including for Medicare Advantage plans, frequently require patients to undergo step therapy, where the patient must first try and fail on another drug—often a less expensive variation—before being allowed to step up to the more expensive medication. Additionally, health payers frequently require patients to apply for prior authorization, where a health care provider must obtain permission from a patient's health plan before accessing health services and critical prescription drugs. While these practices theoretically can control cost, improper use of step therapy and prior authorization delays access to necessary drugs and health services and can lead to negative health outcomes.

When more health plans impose barriers to care, patients face delays in receiving necessary treatments or may be forced to pay out-of-pocket for services that should be covered. Additionally, hospitals must divert valuable staff time and clinical resources to navigate step therapy protocols and overly onerous prior authorization requirements. Denied and delayed payments also contribute to additional financial pressures and operational uncertainty, which harms hospitals' ability to provide care.

As the Committee is considering this legislation, we would ask for clarification regarding the attribution methodology for these arrangements to ensure there is clarity on those populations that are excluded from any cost control or authorization requirements. To the extent possible, MHA would like the attribution methodology to be prospective and to apply across a shared population rather than to specific subgroups to facilitate creation of internal utilization management processes where appropriate.

Maryland hospitals and health systems support SB 475's efforts to eliminate barriers to care. We look forward to our continued partnership with the state and the legislature to create sustainable solutions for access to affordable, comprehensive health care coverage.

For these reasons, we request a favorable report on SB 475 with the proposed amendments.

For more information, please contact:
Jake Whitaker, Assistant Vice President, Government Affairs & Policy
Jwhitaker@mhaonline.org

LBH FWA-SB475 Health Insurance - Utilization Revie

Uploaded by: Jennifer Witten

Position: FWA

LIFEBRIDGE HEALTH

Date: February 12, 2025
To: Chair Beidle, Vice Chair Hayes and Senate Finance Committee Members
Reference: SB475: Health Insurance - Utilization Review - Exemption for Participation in Value- Based Care Arrangements

Position: Favorable with Amendment

Dear Chair Beidle and Committee Members,
On behalf of LifeBridge Health, I appreciate the opportunity to offer our comments for Senate Bill 475. LifeBridge Health is a regional health system comprising Sinai Hospital of Baltimore, an independent academic medical center; Levindale Hebrew Geriatric Center and Hospital in Baltimore; Northwest Hospital, a community hospital in Baltimore County; Carroll Hospital, a sole community hospital in Carroll County; Grace Medical Center (formerly Bon Secours Hospital), a freestanding medical facility in West Baltimore; and Center for Hope a center of excellence focused on provided hope and services for trauma survivors in Baltimore City.

LifeBridge Health appreciates the intention of the bill, however, is concerned that without specific details on shared risk by removing a step that typically would facilitate timely care may create unbalanced risk to the providers. Value-Based Care Arrangements are specially agreed upon contracts with providers and payers, the nuances of these agreements and mechanisms for implementation need to be considered when implementing policy changes proposed in this legislation.

Value-Based Care arrangements are often focused on specific quality metrics alongside cost and utilization targets. Other components – including medical necessity review, cost control mechanisms, and workflow processes may exist today outside of these arrangements. We would want to ensure any changes would be complimentary to our current arrangements, processes and appropriate safeguards/appeal process is in place. As the Committee is considering this legislation, we would ask for clarification regarding the attribution methodology for these arrangements to ensure there is clarity on those populations that are excluded from any cost control or authorization requirements. We would want to understand by removing preauthorization requirements by the insurers does shift more risk to providers in this voluntary arrangement should there be increase unforeseen costs and for what covered patient population.

We ask for a favorable vote with amendments to support holding off on this significant policy change and allow for an interim study with key stakeholders to better define parameters and additional risk that providers who agree to in a two-sided risk arrangement that no longer required preauthorization by carriers.

For more information, please contact:
Jennifer Witten, M.B.A.
Vice President, Government Relations & Community Development
jwitten2@lifebridgedhealth.org