SB 308

Department of Legislative Services

Maryland General Assembly
2023 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 308 (Senators Klausmeier and Hershey)
Finance

Health Insurance – Utilization Review – Revisions

This bill, among other things, (1) alters current requirements for the prior authorization of prescription drugs; (2) alters time periods for grievance decisions; (3) requires carriers to comply with certain requirements when rendering adverse decisions; (4) alters the criteria and standards that must be used by private review agents; (5) alters timelines for certain determinations made by private review agents; (6) requires a private review agent to give the treating health care practitioner the opportunity to speak about the medical necessity of the treatment before issuing an adverse decision; (7) requires existing benchmarks for standardizing and automating preauthorization of health care services and payors' online preauthorization systems to include certain utilization criteria; and (8) increases criminal and administrative penalties for violation of provisions governing private review agents. The bill includes multiple study and reporting requirements involving the Maryland Health Care Commission (MHCC), the Maryland Department of Health (MDH), the Maryland Insurance Administration (MIA), and the Office of the Attorney General's (OAG) Health Education and Advocacy Unit (HEAU). The bill also repeals obsolete provisions and makes conforming changes. **The bill's provisions generally take effect January 1, 2024; the bill's study, reporting, and consumer education requirements take effect July 1, 2023.**

Fiscal Summary

State Effect: Minimal increase in MIA special fund revenues in FY 2024 from the $125 rate and form filing fee. Any additional workload on MHCC, MDH, MIA, and HEAU can likely be absorbed within existing budgeted resources. Expenditures for the State Employee and Retiree Health and Welfare Benefits Program (State Plan) may increase by a significant amount beginning in FY 2024, as discussed below.

Local Effect: To the extent health insurance costs increase under the bill, health care expenditures for local governments that purchase fully insured health benefit plans may increase. Revenues are not affected.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary:

Definitions

The definition of "health care service" is expanded to include a health or medical care procedure or service rendered by a health care provider that provides any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of physical or mental well-being of human beings.

Benchmarks for Standardizing and Automating Preauthorization of Health Care Services

The bill specifies that benchmarks for standardizing and automating preauthorization of health care services must include criteria included in a certificate application by a private review agent. The benchmarks must also require each payor's online preauthorization to approve electronic preauthorization for (1) pharmaceutical services within one *calendar* (rather than business) day after receiving all pertinent information and (2) health care services other than pharmaceutical services that are not urgent within two *calendar* (rather than business) days. A payor's online preauthorization system must comply with any additional utilization criteria required under Title 15, Subtitle 10 of the Insurance Article.

Emergency Services

The bill specifies that the prohibition against prior authorization for covered emergency services includes health care services provided postevaluation or poststabilization that are necessary to discharge the patient.

Prior Authorization for Prescription Drugs

The bill repeals the requirement that a prior authorization request for a prescription drug allow a health care provider to indicate whether a prescription drug is to be used to treat a chronic condition and the prohibition on a carrier requesting reauthorization for a repeat prescription for the prescription drug for one year or for the standard course of treatment for the chronic condition being treated, whichever is less. For a prior authorization *for a*

prescription drug that is filled electronically, the database must prepopulate prior authorization requests with an insured's available insurance and demographic information.

The bill specifies that a carrier that issues an adverse decision denying coverage for a prescription drug must meet all requirements for the complaint process for adverse decisions or grievances and private review agents.

On receipt of information documenting a prior authorization from the insured or the insured's health care provider, a carrier must honor a prior authorization granted to an insured from a previous entity for at least the *lesser of 90 days or the length of the course of treatment*.

A carrier may not require a prior authorization for (1) a change in the dosage of a prescription drug by a prescriber if the entity has already preauthorized the drug for the insured and the dosage change is consistent with U.S. Food and Drug Administration labeled dosages; (2) a generic prescription; or (3) a prescription drug if the insured received an initial prior authorization for the drug and, based on the professional judgment of the prescriber, the prescription drug is effectively treating the insured's medical condition.

A carrier may not require more than one prior authorization for a prescription drug with different formulations that is prescribed through two or more prescriptions at the same time as part of an insured's treatment plan.

Internal Grievance Procedures

Issuing Final Decisions: A carrier must render a final decision in writing on a grievance within *10 calendar* (rather than 30 working) days after the date on which the grievance is filed, absent specified circumstances. For a grievance involving a retrospective denial, a carrier must render a final decision in writing within *30 calendar* (rather than 45 working) days. A carrier may extend the 10-day or 30-day period required for making a final grievance decision with the written consent of a member, the member's representative, or a health care provider who filed a grievance on behalf of the member.

Filing of a Complaint with the Insurance Commissioner: A member, the member's representative, or a health care provider may file a complaint with the Commissioner if they do not receive a grievance decision from the carrier by the *tenth calendar* (rather than thirtieth working) day on which the grievance is filed, as long as they have not already consented in writing to an extension.

Nonemergency Cases: For nonemergency cases, when a carrier renders a grievance decision, the carrier must send a written notice to the member, the member's representative, or the health care provider acting on behalf of the member within *three calendar* (rather

than five working) days after the grievance decision has been made. However, if a carrier renders an adverse decision, the carrier must send such written notice within *two calendar* (rather than five working) days.

Incomplete Grievances: If a member, the member's representative, or a health care provider acting on behalf of a member files a grievance with a carrier, and the carrier lacks sufficient information to complete its internal grievance process, the carrier must notify that individual, within *three calendar* (rather than five working) days of the grievance being filed, that it cannot proceed unless additional information is provided. As part of its notice, the carrier must specify (1) the additional information that must be provided to complete the internal grievance process and (2) the criteria and standards to support the need for additional information.

When a carrier renders an adverse decision in a nonemergency case, the carrier must comply with the following requirements:

- Except as otherwise specified, all adverse decisions must be made by a physician, or a panel of other appropriate health care service reviewers with at least one physician on the panel who is board certified or eligible in the same specialty as the treatment under review and knowledgeable of and has experience in the diagnosis and treatment under review.
- When the health care service under review is a mental health or substance abuse service, the adverse decision must be made by a physician or a panel of other appropriate health care service reviewers with at least one physician who is board certified or eligible in the same specialty as the treatment under review or is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.
- When the health care service under review is a dental service, the adverse decision must be made by a licensed dentist or a panel of other appropriate health care service reviewers with at least one licensed dentist on the panel.

Emergency Cases: A carrier that renders an adverse decision in an emergency case must comply with the same requirements specified above for a nonemergency case. A carrier that renders an adverse decision in an emergency case must send written notice of the decision to the member, the member's representative, or the health care provider acting on behalf of the member within one *calendar* day after the carrier has orally communicated the decision to that individual.

Additional Reporting Requirements

The bill requires that a carrier specify, in the quarterly report submitted to the Commissioner describing its activities, the health care specialty at issue in any adverse

decisions it has made as well as the utilization management technique used by the carrier in issuing those adverse decisions.

Private Review Agents

Certificate of Registration: A private review agent applying for a certificate of registration from the Commissioner must attest that the criteria and standards to be used in conducting utilization review are evidence-based, peer-reviewed, and developed by a professional medical specialty society or another organization, as specified. The criteria and standards to be used in conducting utilization must (1) take into account the needs of atypical patient populations and diagnoses; (2) ensure quality of care and access to needed health care services; (3) be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis; and (4) be evaluated at least annually and updated as necessary.

A private review agent applying for a certificate of registration must submit a list of the persons *and their qualifications, including any certifications and clinical specialties,* involved in establishing the specific criteria and standards to be used in conducting utilization review.

Posting a Copy of Utilization Review Criteria and Standards: The bill repeals provisions requiring a private review agent to provide a copy of the specific criteria and standards to be used in conducting utilization review. Instead, a private review agent must post the specific criteria and standards and any subsequent revisions, modifications, or additions. The posting must include a list of the individuals involved in establishing the specific criteria and standards to be used in conducting utilization review and those individuals' qualifications, including any certifications and clinical specialties.

Making Determinations: The bill alters the following timelines and requirements for a private review agent:

- A private review agent must make all initial determinations on whether to authorize or certify a nonemergency course of treatment for a patient within two *calendar* (rather than business) days after receipt of the information necessary to make the determination.
- A private review agent must make all determinations on whether to authorize or certify an extended stay in a health care facility or additional health care services within one *calendar* (rather than business) day after receipt of the information necessary to make the determination.
- If within *two* (rather than three) calendar days after receipt of the initial request for health care services the private review agent does not have sufficient information to make a determination, the private review agent must specify to the health care

provider the additional information that must be provided *to make the determination and the criteria and standards supporting the need for the additional information*.

Health Care Provider Access to Individual that Rendered Adverse Decision: The bill repeals existing language that gives a private review agent authority to allow a health care provider to speak to the individual that rendered an initial determination not to authorize or certify a health care service. Instead, the bill specifies that, before issuing an adverse decision, a private review agent *must* give the patient's treating physician, dentist, or other health care practitioner the opportunity to speak about the medical necessity of the treatment request with the physician, dentist, or panel responsible for the adverse decision.

Qualification of Physician on Panel who Renders Adverse Decisions: The bill specifies that at least one physician on the panel who renders an adverse decision, in addition to being board certified or eligible in the same specialty as the treatment under review, must be *knowledgeable of and have experience in the diagnosis and treatment under review*. A physician or dentist who makes an adverse decision or participates on the panel that makes an adverse decision must hold a current, valid, and unrestricted license to practice medicine or dentistry in the State.

Reporting and Review Requirements for Private Review Agents: The bill *requires* the Commissioner to establish reporting *and review* requirements to evaluate the effectiveness of private review agents and determine if the utilization review programs are in compliance with applicable law and regulations.

Criminal and Administrative Penalties: The bill increases, from $1,000 to $5,000, the maximum penalty for a private review agent convicted of using criteria and standards for utilization review that do not meet the requirements specified under law. The additional administrative penalty that the Commissioner may impose for each violation of any provision governing private review agents is also increased from $5,000 to $10,000.

Reports and Studies Required Under the Bill

Revised Electronic Processes and Uniform Specifications and Standards: Uncodified language requires MHCC, in consultation with health care practitioners, payors, and the State-designated health information exchange (HIE), to develop findings and recommendations for:

- revising the specified electronic process for health care services to achieve greater standardization and uniformity across payors in order to ease the burden of prior authorizations and other utilization management techniques for patients, providers, and payors;

- replacing the use of proprietary health plan web-based portals with the adoption of uniform implementation specifications and standardization of certification criteria for health care services (including the use of a single sign-on option for payor and third-party administrator websites); and
- a pilot program through the State-designated HIE to implement the changes suggested in MHCC's findings and recommendations.

In consultation with MDH, MHCC must also examine requiring Medicaid managed care organizations to use the standardized electronic process. By December 1, 2023, MHCC must submit a report to the General Assembly on its findings and recommendations, including draft legislation necessary to implement the pilot program.

Development of Standards for Payor Programs: Uncodified language requires MHCC and MIA, in consultation with health care practitioners and payors, to jointly conduct a study on the development of standards for the implementation of payor programs to modify prior authorization requirements for prescription drugs, medical care, and other health care services based on health care practitioner-specific criteria. The study must include an examination of (1) adjustments to payor prior authorization requirements based on a health care practitioner's prior approval rates, ordering and prescribing patterns, and participation in a payor's two-sided incentive arrangement or a capitation program and (2) any other information or metrics necessary to implement the payor programs.

By December 1, 2023, MHCC and MIA must submit a report to the General Assembly that details their findings and recommendations from the study, including recommendations for legislative initiatives necessary for the establishment of payor programs modifying prior authorization requirements based on health care practitioner-specific criteria.

Consumer Education Campaign: MIA, in consultation with OAG's HEAU, must work with medical associations or societies and consumer advocacy organizations to develop an education campaign that can be deployed to educate the public on their rights under Maryland's Health Care Appeals and Grievance Law. The education campaign must be developed by October 1, 2023.

Current Law:

Definitions

"Adverse decision" means a utilization review determination made by a private review agent, carrier, or health care provider that a proposed or delivered health care service is or was not medically necessary, appropriate, or efficient and may result in noncoverage of the health care service. An adverse decision does not include a decision concerning a subscriber's status as a member.

"Grievance decision" means a final determination by a carrier or private review agent that arises from a grievance filed with the carrier or private review agent under its internal grievance process regarding an adverse decision concerning a member or patient.

"Health care service" means a health or medical care procedure or service rendered by a health care provider that (1) provides testing, diagnosis, or treatment of a human disease or dysfunction or (2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

A "private review agent" means a (1) nonhospital-affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of a Maryland business entity or a third party that pays for, provides, or administers health care services to citizens of the State or (2) any person or entity performing utilization review for the purpose of making claims or payment decisions for health care services on behalf of the employer's or labor union's health insurance plan under an employee assistance program for employees other than the employees employed by the hospital or a business wholly owned by the hospital.

"Utilization review" means a system for reviewing the appropriate and efficient allocation of health care resources and services given or proposed to be given to a patient or group of patients.

Benchmarks for Standardizing and Automating Preauthorization of Health Care Services

MHCC must work with payors and providers to attain specified benchmarks for standardizing and automating the process required by payors for preauthorizing health care services and overriding a payor's step therapy or fail-first protocol, including an online preauthorization system, as specified.

Internal Grievance Procedures

Each carrier must establish for its members an internal grievance process, which must meet specified requirements.

A carrier must render a final decision in writing on a grievance within 30 working days after the date on which the grievance is filed, unless a specified exception applies. For a grievance that involves a retrospective denial, a carrier must render a final decision in writing within 45 working days after the date on which the grievance is filed. A carrier may extend the 30-day or 45-day period required for making a final grievance decision with the written consent of the member, member's representative, or the health care provider who filed the grievance.

A member, a member's representative, or a health care provider may file a complaint with the Commissioner if a grievance decision is not received from the carrier by the thirtieth working day on which the grievance is filed.

If a carrier does not have sufficient information to complete its internal grievance process, the carrier must, within five working days after a grievance has been filed, notify the member, the member's representative, or the health care provider who filed the grievance that it cannot proceed with reviewing the grievance unless additional information is provided. Additionally, the carrier must assist the member, the member's representative, or the health care provider in gathering the necessary information without further delay.

For nonemergency cases, when a carrier renders an adverse decision, the carrier must document the decision in writing after the carrier has provided oral communication of the decision to the member, the member's representative, or the health care provider acting on behalf of the member. The written notice must be sent to the member, the member's representative, or the health care provider acting on behalf of the member within five working days after the decision has been made.

In an emergency case, a carrier must provide written notice of a grievance decision to the member, the member's representative, or the health care provider within one day after orally communicating the decision to that individual.

On a quarterly basis, each carrier must submit a report to the Commissioner that describes specified activities, including the number of adverse decisions issued by the carrier and the type of service at issue in those adverse decisions.

Private Review Agents

Certificate of Registration: A private review agent may not conduct utilization review in the State unless the Commissioner has granted the private review agent a certificate of registration. When applying for a certificate, a private review agent must certify that the criteria and standards to be used in conducting utilization review are objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from norms when justified on a case-by-case basis.

A private review agent may not use criteria and standards for utilization review that do not meet these requirements. A person who knowingly uses criteria and standards to conduct utilization review that do not meet these requirements is guilty of a misdemeanor and on conviction is subject to a penalty of up to $1,000. Each day a violation is continued after the first conviction is a separate offense. In addition to that penalty, the Commissioner may impose an administrative penalty of up to $5,000 for each violation of any provision governing private review agents.

A private review agent applying for a certificate of registration must also submit specified information that the Commissioner requires, including a list of the persons involved in establishing the specific criteria and standards to be used in conducting utilization review. The Commissioner may establish reporting requirements to evaluate the effectiveness of private review agents and determine if utilization review programs are in compliance with applicable State law and regulations.

Providing a Copy of Utilization Review Criteria and Standards: On the written request of any person or health care facility, a private review agent must provide one copy of the specific criteria and standards to be used in conducting utilization review of proposed or delivered services and any subsequent revisions, modifications, or additions to the specific criteria and standards to be used in conducting utilization review of such services. A private review agent is entitled to charge a reasonable fee to furnish a copy of the utilization review criteria and standards.

Making Determinations: A private review agent must comply with the following timelines and requirements:

- make all initial determinations on whether to authorize or certify a nonemergency course of treatment for a patient within two working days after receipt of the information necessary to make the determination;
- make all determinations on whether to authorize or certify an extended stay in a health care facility or additional health care services within one working day after receipt of the information necessary to make the determination; and
- if within three calendar days after receipt of the initial request for health care services the private review agent does not have sufficient information to make a determination, the private review agent must inform the health care provider that additional information must be provided.

If a private review agent makes an initial determination not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, the private review agent may grant the health care provider an opportunity to speak with the physician that rendered the determination. The health care provider and physician must speak within 24 hours of the provider seeking the reconsideration.

Adverse Decisions: Except as otherwise specified, all adverse decisions must be made by a physician or a panel of other appropriate health care service reviewers with at least one physician on the panel who is board certified or eligible in the same specialty as the treatment under review.

State Expenditures: The Department of Budget and Management (DBM) advises that the bill increases costs to the State Plan by between 3% and 8% annually ($36.0 million to

$96.0 million) for medical expenses. At this time, DBM cannot estimate the impact on prescription drug costs; however, if the cost increase is the same for prescription drugs as it is for medical expenses, the State Plan could incur an additional $24.0 million to $63.0 million in costs annually for prescription drug expenses. According to DBM, the increased medical costs stem from the bill's limitations on a carrier's ability to provide appropriate utilization management for members. In particular, DBM cites the elimination of subsequent prior authorizations as a major contributor to the potential increased medical costs.

Small Business Effect: Small business health care providers experience reduced administrative burdens under the bill. Due to the bill's changes to the utilization review process, premiums for small businesses that purchase fully insured health benefit plans may increase.

Additional Information

Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: HB 305 (Delegate Kerr, *et al.*) - Health and Government Operations.

Information Source(s): Office of the Attorney General; Judiciary (Administrative Office of the Courts); Department of Budget and Management; Maryland Department of Health; Maryland Insurance Administration; Maryland Health Benefit Exchange; Department of Legislative Services

Fiscal Note History: First Reader - February 16, 2023
js/jc

Analysis by: Ralph W. Kettell

Direct Inquiries to:
(410) 946-5510
(301) 970-5510