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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

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Senate Bill 688- Health Insurance - Utilization Review for Coverage of Prescription Drugs and Devices - Expedited Appeals

Chairwoman Kelley, Vice Chair Feldman and member of the Finance Committee,

When a physician or other clinician prescribes medication or treatment for a patient, the patient's insurance company or pharmaceutical benefits manager (PBM) requires prior authorization before approving coverage. While prior authorization is promoted as a health care savings mechanism[i], this process allows insurers and PBMs to impose extensive paperwork requirements, multiple phone calls, and significant wait times on both prescribers and their patients.

As Maryland physicians continue to be overwhelmed by the pandemic and the need for mental health treatment grows, eliminating these burdensome requirements would alleviate a fraction of their stress and enable them to spend more time with patients in need. Prior authorization often leads to patients experiencing arbitrary limits on medications. When insurers and PBMs decide that patients should not get the treatment physicians have recommended, this is akin to practicing medicine without a license.

Remarkably, there is no clear evidence that prior authorization either improves the quality of patient care or saves money[ii]. Instead, it often results in unnecessary delays in receiving life-sustaining medications or other treatments and leads to physicians spending more time on paperwork and less time treating their patients. For individuals with psychiatric disorders, including those with serious mental illness or substance use disorders, gaps in treatment due to pre-authorization denials can lead to relapse, with increased health care costs and devastating effects for individuals and their families.

This bill would:

1) **eliminate prior authorization for generic medications that are not controlled substances.** These medications are cheap and not addictive; therefore, prior authorization provides no benefit to costs or patient safety.
2) **eliminate prior authorization for dosage strength changes of the same medication**. Patients may often require a dosage adjustment and prescribers should not be constricted by administrative barriers to use their professional judgement.

3) **eliminate prior authorization for generic and brand drugs after patients have been on the medication for six months without interruption.** Once a patient has demonstrated a stable adherence to their treatment plan, his or her prescriber should not be subjected to additional prior authorizations.
4) **require insurers and PBMS adhere to a 48-hour appeal process to ensure timely access to medications for patients.** Too often, patients may suffer serious harm without access to their medication while they wait for insurers or PBMs to approve their medication coverage. For those medications still subject to review, it is imperative that insurers and PBMs provide a timely response to ensure continuity of care.
5) **prohibit plans from denying medication on the grounds of therapeutic duplication if the patient has already been subject to review for the same dosage and it was previously approved.** When a patient requires a certain dosage of medication that is not manufactured in that specific dosage, prescribers may write two corresponding prescriptions to create a unique dose for the patient. Patients are often denied coverage of this medication based on "therapeutic duplication," without recognizing the patient's dosing needs.
6) **require denials and denial reviews be conducted by physicians in the same profession or similar specialty as the health care provider whose recommended treatment is under review.** Insurers and PBMs have been empowered to practice medicine without a license to make coverage denials. Even when a physician is conducting utilization reviews, a psychiatrist may receive a denial from a cardiologist, who lacks the clinical expertise. This change would ensure that denial and denial reviews are overseen by an expert who is familiar with the treatment plan and type of patient under review.

In conclusion, patients need timely access to medication. Please support legislation that makes common sense changes to prior authorization. I urge a favorable on Senate Bill 688.

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[i] American Medical Association. *2021 AMA Prior Authorization (PA) Physician Survey.* 2021.

[ii] American Medical Association. *Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitative analysis of physician and staff interviews.* October 2016.