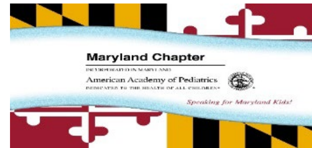

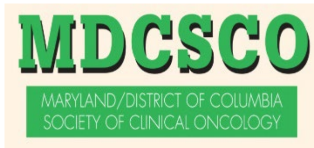

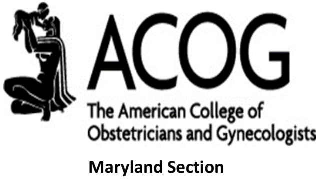

TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Katherine Klausmeier

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Andrew G. Vetter
Christine Krone
410-244-7000

DATE: February 21, 2024

RE: **SUPPORT** – Senate Bill 791 – *Health Insurance – Utilization Review – Revisions*

On behalf of The Maryland State Medical Society, the Maryland Academy of Family Physicians, the Maryland/District of Columbia Society of Clinical Oncology, the Maryland Section of The American College of Obstetricians and Gynecologists, the Mid-Atlantic Association of Community Health Centers, and the Greater Washington Society for Clinical Social Work, we submit this letter of **support** for Senate Bill 791.

Senate Bill 791 is a modified reintroduction of Senate Bill 308 from the 2023 Session.[1] The bill is a result of a workgroup convened during the 2023 Interim, where almost a dozen meetings took place between physicians, health care practitioners, and payors along with their representatives and parties to reach agreement on the bill's provisions, prior to introduction. Therefore, Senate Bill 791 makes changes to the utilization review policies used by health insurance carriers to determine when a requested health care service is medically necessary to ensure that decisions are being made timely and are based on appropriate clinical and medical standards. Most importantly, Senate Bill 791 contains a provision that will allow a patient to remain on a medication when that medication was previously approved by the patient's insurance company and the patient has been well-maintained on that medication. Most often, this scenario affects patients with serious mental illness or other chronic conditions (i.e., autoimmune diseases, hypertension, diabetes) whose treatment plan requires the use of maintenance drugs.

Utilization review policies used by insurance carriers are negatively affecting patients, by either denying or delaying necessary care. A recent survey by the American Medical Association found that 93% (more than 9 out of 10) of physicians reported delays in access to necessary care and 82% (more than

[1] A similar bill was also introduced in the 2022 Session. [2022 Regular Session - Senate Bill 688 First Reader (maryland.gov)]

8 out of 10) of physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials. Equally important is the data from the Maryland Insurance Administration's (MIA) 2022 Report on the Health Care Appeals and Grievances Law (released December 1, 2023) that shows the number of denials of care continues to increase year after year. In 2022, the number of denials reported from the insurance carriers to the MIA was 95,327 whereas in 2021 that number was 81,143. In 2022, MIA modified or reversed the carrier's decision (or the carrier reversed its own decision during the course of investigation) 72.4% of the time, up from 70.5% in 2021. This means that in more than 7 out of 10 cases, the MIA ruled that the carrier was wrong, and that the patient should have received the health care service.

Senate Bill 791 achieves the following:

1. **Reducing/Streamlining the Volume of Prior Authorization Requirements**

   a. Prohibiting a carrier from issuing a denial of care when a patient requests a medication renewal if the insurer previously approved the drug, the patient has been successfully treated on the prescription drug, and the prescriber attests that the patient continues to need the drug.
   b. Exempting prescription drugs from requiring a prior authorization for dosage changes provided that the change is consistent with federal FDA labeled dosages and is not an opioid.
   *** Maryland law already prohibits prior authorization for a prescription drug when used for treatment of an opioid use disorder and that contains methadone, buprenorphine, or naltrexone.*
   c. Requiring a carrier to allow a patient who changes health insurance carriers to remain on the patient's medication for a period of the lesser of 90 days or the course of treatment during which time the new carrier can perform its own prior authorization review.
   d. Requiring a carrier to provide 60 days' notice rather than the current 30 days' notice when it implements a new prior authorization requirement.
   e. Requiring that a carrier, when approving a prior authorization request, to approve a course of treatment of a non-medication health care service for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation.

2. **Increasing Transparency and Communication as Part of the Review Process**

   a. Ensuring that the decision of when a case requires an expedited review after a denial is based on the determination of the health care provider and not the carrier (i.e., expedited reviews must be conducted within 24 hours).
   b. Requiring that any communication from the carrier where there is a denial of health care services states in detail the factual bases for the decision that explains the reasoning why the health care provider's request was not medically necessary and why it did not meet the criteria and standards used in conducting the review, which must be specifically referenced and not simply referred to "as part of the member's policy or plan document."
   c. Requiring carriers to have a dedicated call line or dedicated/monitored email address for denials so that health care providers can discuss the decision or schedule a time to discuss with the carrier, rather than having to go through the general customer call line.
   d. Requiring that if any additional information is needed to make the determination, the carrier must provide the specific information needed, including any lab or diagnostic test or other medical information, along with the criteria and standard used to support the need for the additional information.

e. Adding new reporting requirement within the annual report on utilization review by the MIA to determine how many patients requested a formulary or copay tier exception when changes have occurred to either.
f. In addition to satisfying other factors, eliminating "homegrown" criteria in favor of requiring carriers to utilize criteria and standards that are developed by nonprofit medical or clinical specialty societies or organizations that work directly with health care providers in the same specialty.
g. Mandating that a "peer to peer" must occur if requested by the health care provider (currently – it is discretionary).
h. Mandating that if the carrier does not meet the required times for making a determination, the request is deemed approved.

3. **Future Review Changes**

a. Studying whether to implement changes to the prior authorization requirements based on a health care provider's prior practice (otherwise known as the "gold card").
b. Reviewing whether to eliminate prior authorization requirements when a health care provider participates in a value-based arrangement.
c. Imposing a future requirement (2026) that carriers' electronic processes must integrate with all electronic health records to provide real time benefit information on a patient's coverage at no cost to the health care provider.

With these changes, we believe that patients will be able to access needed health care services in a timely manner and will improve the accountability and understanding of current processes used. We urge a favorable vote.