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Hello and good afternoon. My name is Dr Gina Campbell Moore, and I am a retired physician with a background in obstetrics and gynecology.

I would like to thank the honorable members of this committee for the opportunity to provide testimony today in support of Senate Bill 961, legislation to ensure access to critical pharmacogenetic testing services for Maryland patients.

Currently, I serve as a Vice President in Market Access with Myriad Genetics, a company that, since 1991, has discovered and commercialized genetic tests that help determine the chances of developing diseases, assess the risk of disease progression, and guide treatment decisions across medical specialties.

Today, Maryland is grappling with rising levels of mental illness, worsened by a shortage of mental health providers and facilities, especially in rural and underserved communities. Mental healthcare providers urgently need tools and solutions to address this growing crisis and assist their patients in recovery.

One such tool is pharmacogenomic mental health testing, which would be covered under SB 961. Pharmacogenomic tests, which only need to be administered once in a patient's lifetime, evaluate genetic variants that affect how a drug is metabolized or acts on a patient's body. Clinically validated pharmacogenomic tests offered by precision medical laboratories like Myriad must be ordered by a licensed clinician. The test results provide valuable data to providers, helping to inform medication selection or dose optimization—significantly enhancing patient outcomes, improving quality of life, and reducing healthcare costs. These tests offer comprehensive insights into how a patient’s clinically relevant genetic variations may impact outcomes with commonly prescribed psychiatric medications and can help reduce trial-and-error prescribing. Pharmacogenomic mental health tests have already been covered by the federal Medicare Program for over a decade, as well as by many State Medicaid programs and some large commercial insurance carriers.

When mental health is managed effectively, overall healthcare management improves. For example, controlling severe depression enhances the management of comorbid conditions like diabetes or heart disease. Swift stabilization of psychiatric patients by avoiding prolonged medication trials can prevent psychiatric-related hospitalizations, unnecessary trips to state detention facilities, and allow patients to return to their lives and work sooner.

For these reasons, I urge members of this committee to safeguard patient access to pharmacogenomic testing for patients in Maryland by supporting the passage of Senate Bill 961.

Thank you

Gina Campbell Moore, MD, MBA, FACOG

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Uploaded by: Matthew Celentano
Position: UNF

The League of Life and Health Insurers of Maryland

15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

February 26, 2025

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

Senate Bill 961 – Maryland Medical Assistance Program and Health Insurance - Pharmacogenomic Testing - Required Coverage

Dear Chair Beidle,

The League of Life and Health Insurers of Maryland, Inc. respectfully opposes *Senate Bill 961 – Maryland Medical Assistance Program and Health Insurance - Pharmacogenomic Testing - Required Coverage* and urges the committee to give the bill an unfavorable report.

The League and our members are committed to finding ways to cover all screenings and medically necessary servicers when appropriate, but we unfortunately cannot support this approach, especially without premium impact analysis. We are unclear what the impact to plans would be to mandate coverage for single-gene and multigene pharmacogenomic testing. Coverage is typically based on a patient's individual medical history, current medications, and diagnosis, ensuring the test is relevant to their specific clinical situation, but that doesn't mean that it is appropriate for every patient. Most carriers cover forms of pharmacogenomic testing already, so we are unclear if the mandate is needed.

Under the ACA, each state must pay for every health plan purchased through the Maryland Health Benefit Exchange, the additional premium associated with any state-mandated benefit beyond the federally mandated essential health benefits. This means, should the Commissioner include the mandate in the State benchmark plan, the State would be required to defray the cost of the benefits to the extent it applies to the individual and small group market ACA plans.

The League opposes any additional mandated benefits to Maryland's law. Mandated benefits add cost to health insurance policies in our state and limit the ability of insurers to design benefits to best meet the needs of enrollees. Given the potential impact to health insurance costs in the State, Maryland law includes a statutory framework for review and evaluation of proposed mandated benefits by the Maryland Health Care Commission under § 15-1501 of the Insurance Article. The law requires the assessment of a proposed mandate for the social, medical and financial impact of the proposed mandate and equips the General

Assembly with such information as the extent to which the service is generally utilized by a significant portion of the population; the extent to which the insurance coverage is already generally available; if coverage is not generally available, the extent to which the lack of coverage results in individuals avoiding necessary health care treatments; if coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship; and the level of public demand for the service. Before adopting this or any other mandated health benefit, we urge the Committee first request an evaluation of the proposed benefit to facilitate an informed decision.

For these reasons, the League urges the committee to give Senate Bill 961 an unfavorable report.

Very truly yours,

Matthew Celentano
Executive Director

cc: Members, Senate Finance Committee

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Position: INFO

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 26, 2025

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Office Building
Annapolis, MD 21401-1991

Re: Senate Bill (SB) 961 – Maryland Medical Assistance Program and Health Insurance – Pharmacogenomic Testing – Required Coverage – Letter of Information

Dear Chair Beidle and Committee members:

The Maryland Department of Health (the Department) respectfully submits this letter of information for Senate Bill (SB) 961 – Maryland Medical Assistance Program and Health Insurance – Pharmacogenomic Testing – Required Coverage.

SB 961 requires the Maryland Medical Assistance Program and certain health insurers, nonprofit health services plans, and health maintenance organizations to provide coverage for single-gene and multigene pharmacogenomic testing if the testing is ordered by a treating provider for an insured or enrollee with a diagnosis of depression or anxiety. SB 961 also limits the prior authorization requirements that certain health insurers, nonprofit health services plans, and health maintenance organizations may implement for pharmacogenomic testing. This bill also has penalties of up to $10,000 per instance of non-compliance for managed care organizations (MCOs) that do not comply and an additional penalty of $1,000 per day that the non-compliance continues after notification from the Department.

The Department already covers all of the services outlined in this bill. As drafted, the legislation does not define a specific time frame for review of prior authorization requests; however, the Department believes its existing standards comport with the bill's intent. Further information on the current prior authorization policies are detailed below.

For Fee for Service (FFS) participants, the Department does not require prior authorization for most of these tests. Of the three applicable CPT codes, only 81479: Non-Invasive Prenatal Testing requires a preauthorization. A determination must be made for laboratory FFS prior authorization requests within 72 hours of the provider submitting a preauthorization request form.

Any MCO that implements prior authorization must follow existing standards in COMAR, which are in compliance with the bill as written. According to COMAR 10.67.09.04, MCOs must make a determination within two business days of receipt of necessary clinical information, but not later than 14 calendar days from the date of the initial request. For expedited

authorization decisions, the MCO shall make a determination and provide notice no later than 72 hours after receipt of the request for service if the provider indicates or the MCO determines that the standard time frame stated above could jeopardize the patient's life, health, or ability to attain, maintain, or regain maximum function. For all covered outpatient drug authorization decisions, the MCO shall provide notice within 24 hours of a preauthorization request.

If you would like to discuss this further, please do not hesitate to contact Sarah Case-Herron, Director of Governmental Affairs at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary