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Testimony in Support of HB 659
Health Insurance – Utilization Review –
Exemption for Participation in Value-Based Care Arrangement

Good afternoon, Madame Chair Peña-Melnyk, and honorable members of the Health and Government Operations committee. Thank you for the opportunity to present for your consideration **HB 659: Health Insurance – Utilization Review – Exemption for Participation in Value-Based Care Arrangement.**

Utilization Review/Management is one of the most hated concepts in the practice of modern medicine. It is a defined relationship between a medical practitioner and an insurance carrier. The practitioner diagnosis you and based on the best of their knowledge and experience, prescribes a treatment, could be a pharmaceutical, medical intervention, or any one of another kind of therapy, such as physical or occupational therapy. They then submit their prescription to the insurance company for utilization review This is called pre-authorization. Most of the time, carrier agrees to the treatment plan and pays for it; when it does not either the patient and practitioner agree to the alternative plan recommended by the carrier, or they appeal the decision. In most cases, the carrier reviews the treatment plan periodically and must be re-authorized.

Responding to and appealing denials is a tedious process. Last year we passed legislation that clarified the regulated processes to appeal the carrier's decision with respect to types of information that must be disclosed in the denials and the timelines for notification and feedback. It went into effect on January 1, 2025, so we should see some improvement. We did not eliminate the requirements for pre- and re-authorization except for a few specialized pharmaceutical treatments. It does have a place in the way-out current system works. It is a sort of check and balance on practitioners, to assure they are basing their decisions on the best factors to determine medical necessity and the most current medical information. Not necessarily a welcomed check and balance, but it is a responsibility of the insurance carrier to support the best patient outcomes, while maintain the solvency of the company.

In 2022, we passed legislation to allow practitioners and insurance carriers to engage in a different kind of relationship. There is a national movement in health care away from fee-for-service payment, where the focus is on high-volume care, and towards value-based care that puts patients' needs and their health outcomes at the center of care delivery. When providers are engaged in **value-based partnerships**, their success and financial incentives depend on improving patients' health, not just if they received a medical service. Providers in value-based partnerships are empowered to address their patients' care needs holistically by focusing on coordinated care that proactively identifies gaps in treatment and social risk factors. These are core elements to a healthy life but are repeatedly overlooked in a fee-for-service relationship when the economic incentives are not tied to health outcomes. The framework **encourages providers to address health equity, social determinants of health, and improve the patient experience**.

Our law ensures that participation in value-based arrangements is voluntary, and that practitioners are protected should they choose not to participate. It contains numerous additional patient and provider protections that are unparalleled in federal programs or laws or private contracts in other states, including but not limited to:

- A requirement that a bonus or two-sided incentive arrangement must promote health equity, improvement of healthcare outcomes and the provision of preventive healthcare services.
- A requirement that these arrangements must be voluntary, and a carrier cannot require providers to participate in a two-sided arrangement to participate in the carrier's provider network.
- An opportunity for an audit by an independent third party and an independent third-party dispute resolution process.
- Protects providers by setting a maximum downside risk that a provider can agree to in any arrangement and the opportunity for gains must be greater than the amount that can be recouped.

In speaking with a carrier who is heavily invested in value-based care relationships, I learned that over 100,000 of their members are now covered by one or more practitioner with a value-based contract. Early assessments of these arrangements are showing great promise in quality of patient outcomes, consumer satisfaction and affordability.

In an extremely basic analysis, the utilization review process and the value-based care models share the same goals-- good health outcomes while being financially responsible. If that is the case, then why not let those practitioners who have signed value-based contracts be exempted the more traditional utilization management. In a contract where they are paid not based on the number of patients they see, but how well their patients do, they have agreed to a certain amount of financial risk. Their payment is based on goals that have been mutually agreed to between the practitioner and the carrier. They have skin in the game.

Many other states allow for value-based contracts, but we could find only one that prohibits payers from requiring prior authorization for services included in value-based care models, which is Arkansas. Maryland could lead once again in good medical practice. There is a safeguard, the contracts are time limited. If the expected patient outcomes are not realized, the review processes could be reinstated.

This is a novel concept; one that I believe merits discussion and exploration. For that reason, I humbly request a favorable report for HB 659.