SUPPORT: Senate Bill 791/House Bill 932
Reforming Prior Authorization and Utilization Review Policies

Utilization Review Techniques Hurts Patients

Health insurance carriers engage in a process known as "utilization review," which is a process where the carrier, in advance of a health care service being rendered, reviews the request to determine if the service is medically necessary. The two most common types are "prior authorization," which is requesting approval in advance from the carrier and "step therapy," where the patient must try and fail on other medications (often less expensive) before being able to take the medication preferred by the prescriber.

- Despite increased scrutiny and pressure on the national level, carriers continue to increase denials of care (i.e., adverse decisions). The 2022 Report on the Maryland Health Care Appeals and Grievances Law (released December 1, 2023) reports that Maryland carriers rendered 95,327 adverse decisions, up from 81,143 adverse decisions in 2021.
- Similar to last year, the Maryland Insurance Administration (MIA) modified or reversed the carrier's decision (or the carrier reversed its own decision during the course of investigation) 71% of the time on filed complaints. This means that in more than seven out of ten cases, the MIA ruled that the carrier was wrong, and that the patient should have received the health care service, resulting in patients receiving $649,590 back in health care costs.
- This data supports the concerns raised by physicians. In 2021, the American Medical Association conducted a survey on the impact that prior authorizations have on physicians and patients and found that 93% of physicians reported delays in access to necessary care; and 82% of physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials.

Reforming Utilization Review

During the 2023 interim, members of the General Assembly worked with physicians, health care practitioners, patient advocacy organizations and insurance carriers to craft legislation to reform the utilization review process, resulting in legislation for the 2024 Session.

Senate Bill 791/House Bill 932 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 doing 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 for denials so that health care providers can discuss the decision 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 Maryland Insurance Administration 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) and that the licensed physician/dentist must not only be board certified or eligible in the same specialty but also knowledgeable about the requested health care service or treatment through actual clinical experience.
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.