December 9, 2024

The Honorable Bill Ferguson
President of the Senate
H-107, State House
100 State Circle
Annapolis, MD 21401

The Honorable Adrienne A. Jones
Speaker of the House of Delegates
H-101, State House
100 State Circle
Annapolis, MD 21401

Re: SB 791/CH 848 and HB 932/CH 847, (2024), *Health Insurance – Utilization Review – Revisions* – Final Report (MSAR #15340)

Dear President Ferguson and Speaker Jones:

Chapters 848/847 (SB 791/HB 932), *Health Insurance – Utilization Review – Revisions* (2024) require the Maryland Health Care Commission (MHCC) and the Maryland Insurance Administration (MIA) to jointly study the development of standards for implementing payor programs aimed at modifying prior authorization requirements for prescription drugs, medical care, and other health care services. The law also mandates a review of literature and initiatives being implemented or considered in other states.

The report summarizes findings from an environmental scan of the prior authorization process, including national and state-level policies aimed at promoting greater transparency, reducing response times, improving interoperability, and decreasing the volume of prior authorizations. It also covers real-time benefit tools, prescription drug coupons, and adverse decisions in Maryland. The report includes three recommendations focused on prior authorization reporting, technology, and monitoring.

We appreciate your consideration. If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at ben.steffen@maryland.gov or 410-764-3566 or Marie Grant at marie.grant1@maryland.gov or 410-468-2408.

Sincerely,

Ben Steffen
Ben Steffen
Executive Director, MHCC

Marie Grant
Acting Commissioner, MIA

cc:
The Honorable Wes Moore, Governor
The Honorable Pamela Beidle, Chair, Senate Finance
The Honorable Joseline A. Pena-Melnyk, Chair, House Health and Government Operations Committee
The Honorable Laura Herrera Scott, Secretary, Maryland Department of Health
Erin McMullen, Chief of Staff, Maryland Department of Health
Jonny Dorsey, Deputy Chief of Staff, Governor's Office (on behalf of Governor Moore)
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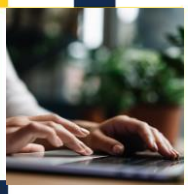
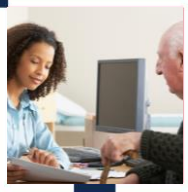
Tracey DeShields, Director of Policy Development and External Affairs, MHCC

Health Insurance – Utilization Review – Revisions





An Environmental Scan of the Prior Authorization Process

November 21, 2024

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CHAIRMAN

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND Health Care Commission

Maryland INSURANCE ADMINISTRATION

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MARYLAND LAW

Chapter 848 (Senate Bill 791) and Chapter 847 (House Bill 932), *Health Insurance - Utilization Review - Revisions*[1] ("Act") of the 2024 Laws of Maryland alters and establishes requirements and prohibitions related to health insurance utilization review; alters requirements related to internal grievance procedures and adverse decision procedures; alters certain reporting requirements on health insurance carriers relating to adverse decisions; and establishes requirements on health insurance carriers and health care providers relating to the provision of patient benefit information. By July 1, 2026, payors are required to implement changes to the electronic prior authorization process for pharmaceuticals by linking directly to all e-prescribing and electronic health record ("EHR") systems using the National Council for Prescription Drug Programs ("NCPDP") standards,[2] accepting prior authorization requests from a provider, approving prior authorization requests, and linking to real-time patient out-of-pocket costs (copayment, deductible, and coinsurance) and more affordable medication alternatives available.

The Act requires the Maryland Health Care Commission ("MHCC") and the Maryland Insurance Administration ("MIA"), in consultation with providers and commercial payors ("payors"), to conduct a study on the development of standards for modifying prior authorization requirements for prescription drugs, medical care, and other services based on health care practitioner-specific criteria. The study must consider adjustments to prior authorization requirements that have been implemented or considered by other states. Findings and recommendations are due to the General Assembly by December 1, 2024.

APPROACH/LIMITATIONS

An environmental scan ("scan") was conducted centering on select policy and technical aspects related to prior authorization processes. This included a literature review of federal and state-level approaches to reform prior authorization. Policies to advance access to interoperable patient data among payors and providers are noted, as well as perspectives on prescription drug coupons and adverse decisions in Maryland (Figure 1). Lewis and Ellis, LLC was competitively selected to support the scan.

Scan results provide a broad overview of the prior authorization landscape based on available data and literature. An in-depth qualitative and quantitative analysis was beyond the scope of this assessment. Further research is needed to make informed recommendations for policy reforms in prior authorization.

[1] See Appendix B for a copy of the law.

[2] The NCPDP SCRIPT Standard is widely used as the core standard for e-prescribing to support electronic data transfer for new prescriptions, prescription modifications, refill requests, prescription fill status notifications, prescription cancellations, and medication history; the standard supports the process of determining if prior authorization is needed, requesting and communicating prior authorization approval, and appealing adverse decisions. More information is available at: www.ncpdp.org/Resources/ePrescribing-Industry-Information.

Figure 1:

Scan Activities

1. Review published research in journals and other publications to understand the current landscape, identify knowledge gaps, and build on what is already known;
2. Identify legislative initiatives in other states to understand their design and impact; and
3. Explore approaches to adjust prior authorization requirements based on a practitioner's approval rates, prescribing patterns, and participation in incentive programs.

RECOMMENDATIONS

Prior Authorization Reporting, Technology, and Monitoring

1. ***Assess the impact of commercial payors including an indicator on claims that required prior authorization, in quarterly submissions to MHCC's All Payer Claims Database ("APCD"), starting in 2026.***

   Rationale

   Reporting prior authorization metrics provides a foundation to enable sound regulatory oversight and increase transparency. Including prior authorization information on claims submitted to the APCD will allow for a general measurement of spending to assess the impact of prior authorizations on payors, provider specialties, and consumers.[3] Payors report quarterly census data on adverse decisions to the MIA.[4] Newly required information on prior authorization volumes under Senate Bill 791/House Bill 932 will help measure frequency and outcomes of adverse decisions by payor.

2. ***Require electronic health record ("EHR") vendors to implement an electronic prior authorization application programming interface ("API") in accordance with the Centers for Medicare & Medicaid Services ("CMS") Interoperability and Prior Authorization Final Rule (January 1, 2027).[5] Encourage commercial payors to use an API implementation guide specified by CMS.***

[3] The ACPD includes enrollment, provider, and claims data for Maryland residents enrolled in private insurance including Medicare Advantage, Medicare fee-for-service, and Medicaid Managed Care Organizations. These data play an important role in health services research, policy making, and health care system transparency.
[4] Required by Insurance Article § 15-10A-06.
[5] The CMS Final Rule mandates EHR vendors ensure the "*API will be accessible to providers to integrate directly into their workflow*" and does not require integration.

Rationale

EHR vendors can bypass electronic prior authorization requirements by engaging a third-party intermediary to provide certain functionalities. Stakeholders have expressed concern that without a mandate for EHR vendor adoption of the prior authorization API, providers may struggle to identify prior authorization requirements, retrieve necessary patient data, and exchange requests and responses with payors within their workflows.[6] CMS does not designate a particular electronic prior authorization API implementation guide; however, it recommends several that align with national standards.[7]

3. ***Monitor the implementation and impact of the 2024 law (Chapter 848/Senate Bill 791 and Chapter 847/House Bill 932) and any future amendments on providers and commercial payors and submit an annual report to the legislature through 2028.***

Rationale

Continuous monitoring helps ensure implementation of new prior authorization requirements are reasonably progressing. It provides opportunities to identify policies and practices that may need to be reviewed to address delays in care, administrative burdens, and other issues that could negatively impact patient outcomes. Payors and EHR vendors view the federal requirements as complex, necessitating the need to reengineer their systems and software. Ongoing assessments are crucial to inform future legislative considerations that maximize the benefits of prior authorization reform for patients, providers, and payors.

BACKGROUND

In the 1960s, the federal government began addressing health care quality and costs by implementing provider-based utilization management within Medicare and Medicaid to prevent the overuse of medical services and prescription drugs. Prior authorization is meant to safeguard patients and is commonly used by payors; however, the process can delay treatment.[8] Payor requirements for prior authorization vary and are influenced by medical guidelines, costs, utilization rates, state and federal laws and regulations, and feedback from providers.[9]

Providers typically report administrative burdens associated with the prior authorization process.[10] Providers contend that the need to submit detailed documentation, navigate varying requirements across different payors, and wait for payor responses diverts time and resources away from patient

[6] The Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT oversees the Health IT Certification Program and is considering ways to address this issue in future rulemaking.
[7] More than 25 years ago, a medical prior authorization standard (i.e., X12 278 prior authorization standard) was named in the HIPAA Transaction and Code Set Rule; however, it is considered an unworkable solution and adoption has been limited.
[8] National Health Council, *NHC Report: Exploring the Burden of Prior Authorization on Patients with Chronic Disease*. Available at: nationalhealthcouncil.org/research-briefs/nhc-report-exploring-the-burden-of-prior-authorization-on-patients-with-chronic-disease/.
[9] California Health Benefits Review Program, *Prior Authorization in California*, October 11, 2023. Available at: www.chbrp.org/sites/default/files/bill-documents/Prior%20Authorization_final.pdf.
[10] Yang E, Yang S. *Prior Authorization: Overwhelming Burden and Critical Need for Reform*. JACC Case Rep. 2020 Aug 19;2(10):1466-1469. doi: 10.1016/j.jaccas.2020.05.095. PMID: 34316998; PMCID: PMC8302155.

care. This can adversely affect outcomes and lead to dissatisfaction among patients and providers. Prior authorization is often required for routine and high-cost medications and services. A national survey conducted in May 2024 found that nearly 48 percent of insured adults noted their insurance required prior authorization in the last year. About 67 percent of these adults indicated that prior authorization delayed access to prescribed medication and medical services.[11]

Federal efforts to reform prior authorization are underway and aim to improve speed and efficiency in prior authorization decision-making through the standardized exchange of electronic information. In 2022, CMS introduced a Proposed Rule to expand access to health information and improve the prior authorization process for federally regulated payors (Medicare Advantage Organizations, Medicaid and the Children's Health Insurance Program, Medicaid managed care plans, and state Qualified Health Plans).[12] CMS considered public input and complexities with the implementation of new rules and standards for electronic data exchange. The Final Rule became effective in April 2024 and focuses solely on medical items and services, excluding prescription drugs.[13]

The Final Rule will enable electronic submission of prior authorization requests and responses. Payors will need to implement and maintain technology that leverages providers' EHR systems to automate the prior authorization process[14] (effective January 2027). Payors are required to issue decisions on standard (non-urgent) prior authorization requests within seven calendar days and expedite (urgent) prior authorization requests within 72 hours (effective January 2026). The Final Rule mandates that payors specify the reason for denying a prior authorization request to ease challenges related to resubmissions or appeals. Payors are also required to publicly report certain prior authorization metrics.

STATE SNAPSHOT – ADJUSTMENTS TO PAYOR PRIOR AUTHORIZATION REQUIREMENTS

Many states have taken steps to address challenges with the prior authorization process. Approaches vary from requirements on transparency and response times to automating prior authorization through electronic methods; select states have legislation to limit certain prior authorization requirements based on prior approval rates and ordering and prescribing patterns (see Appendix C).[15]

The following highlights national and regional actions (includes Maryland and boarding states – Delaware, Pennsylvania, Virginia, West Virginia, and the District of Columbia) to reform the prior authorization process. The list is not exhaustive of all prior authorization reform efforts.

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[11] Patient Access Network Foundation, *Nearly Half of Insured Adults Have Faced Prior Authorization Requirements In The Past Year*, May 2024. Available at: www.panfoundation.org/nearly-half-of-insured-adults-have-faced-prior-authorization-requirements-in-the-past-year/#:~:text=A%20recent%20national%20poll%20from,authorization%20in%20the%20past%20year.

[12] CMS Proposed Rule, December 13, 2022, Federal Register, "*Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations* (partial title)" available at: www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

[13] KFF, *Final Prior Authorization Rules Look to Streamline the Process, But Issues Remain*, May 2, 2024. Available at: www.kff.org/private-insurance/issue-brief/final-prior-authorization-rules-look-to-streamline-the-process-but-issues-remain/.

[14] Includes identifying whether a medical service requires prior authorization, specific rules and documentation requirement, and populating prior authorization forms directly from the EHR.

[15] The information that follows was largely obtained from research conducted by the American Medical Association. State laws are as of January 2024, except Maryland which includes legislation signed into law on May 16, 2024 (Chapter 848). Available at: www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf.

Electronic Methods

- About 28 states, including Maryland, Pennsylvania, and West Virginia, require electronic processes for prior authorization; requirements include proprietary online portals and the use of certain data exchange standards.[16]
- Maryland is among approximately 12 states, including Delaware, Virginia, and the District of Columbia,[17] that have enacted legislation requiring payors to accept and respond to prior authorization requests for prescription drugs using data exchange standards established by the NCPDP.[18]
- California, Colorado, and Tennessee are among the first states to enact legislation aligning with federal requirements for payors to establish and maintain API communication standards to automate information exchange between the providers and payors for prior authorization of medical items and services.[19]
- A stakeholder workgroup in Virginia recommended that legislation be proposed to align with federal API requirements.[20]

Response Times

- Maryland is among most states (nearly 41) that require payors to respond to prior authorization requests within specified time periods, which vary for pharmacy and medical services ranging from 24 hours to 15 days.[21]
- Maryland's response times are generally more stringent; prescription drugs require a real-time response for an electronically submitted request when the request does not require additional information.
- Effective January 1, 2025, Maryland law provides a two working day timeline for a non-emergency course of treatment and 24 hours for an emergency course of treatment.[22] Maryland law also requires a response within two hours for certain emergency admissions for mental health and substance use disorder treatment. A prior authorization request will be deemed approved if the determination is not made within the required response time.

Exceptions

- About 16 states, including Maryland, prohibit the use of prior authorization for certain specialties, drugs, conditions, or circumstances.[23]

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[16] Use of online portals is more common for medical services, and the process often still relies on fax and call centers.
[17] States include: CO, DE, GA, IN, KY, MD, ME, MN, NJ, OH, TN, VA.
[18] See n. 2, *Supra.*
[19] 45 CFR 170.215 (a): www.ecfr.gov/current/title-45/subtitle-A/subchapter-D/part-170/subpart-B/section-170.215
[20] Commonwealth of Virginia, *Report of the Electronic Prior Authorization Work Group*, November 1, 2023. Available at: rga.lis.virginia.gov/Published/2023/RD574/PDF.
[21] Factors typically include one or more of the following: whether a prior authorization is for an urgent or non-urgent request, a prescription or medical service, or electronic or manual submission (i.e., phone, fax, or mail).
[22] Except for electronically submitted prior authorization requests for prescription drugs.
[23] Provisions are intended to address situations where delays are particularly problematic for patients who require services and medication for specific chronic or terminal conditions (TX, AK), perioperative care (LA), childbirth and neonatal care (KY, NY), treatment for certain mental health conditions (MT, NH), and unanticipated emergency services (DC, GA).

- Roughly 11 states, consisting of Maryland and most of its boarding states (Delaware, Virginia, West Virginia, and District of Columbia), do not require prior authorization for medications for substance use disorder.[24] Certain states (Maine, Virginia, West Virginia) require payors to offer at least one medication for opioid use disorder that is not subject to prior authorization.
- Montana prohibits prior authorization for generic drugs prescribed to a patient for more than six months and for any drug when the dosage changes.[25]
- Arkansas does not allow payors to require prior authorization for services included in value-based care models effective January 1, 2024.

Reporting

- About 19 states mandate payors report certain data on prior authorizations.[26]
    - 14 states[27] require reporting on the total number of prior authorization requests, denials, and approvals.
    - 11 states[28] require reporting of the response time between prior authorization request and approval.
    - Four states[29] require reporting on the most common specialties, services, and reasons for prior authorization denials.
- Maryland and Pennsylvania require payors to report total adverse decisions, and the number of decisions reversed upon appeal. Effective January 1, 2025, Maryland will require payors to report the number of adverse decisions that involved prior authorization or a step therapy protocol.
- Virginia requires reporting on total complaints pending and closed related to prior authorization.

Gold Carding

- About five states (Arkansas, Louisiana, Michigan, Texas, and West Virginia) require payors to establish programs that exempt providers from prior authorization if certain conditions are met. Eligibility is determined based on prior authorization approval rates and adherence to nationally recognized evidence-based medical guidelines.
    - Three of these states (Arkansas, Texas, and West Virginia) set criteria for provider eligibility, which generally involves a 90 percent approval rate for a service within a six-month or 12-month period; two states (Louisiana and Michigan) do not set clear requirements around program design, giving payors flexibility to develop program eligibility requirements and applicable services and procedures.

[24] States include: AZ, CT, DC, IL, MD, MO, MT, NJ, NY, TN, WV.
[25] If dosing is consistent with FDA guidelines.
[26] Data is reported on payors websites or to a specified state agency.
[27] States include: CA, DC, DE, GA, IL, LA, MI, MN, NJ, NM, OR, TN, TX, WV.
[28] States include: CA, DC, GA, IL, LA, MI, MN, NJ, NM, UT, WA.
[29] States include: IL, IN, MI, WA.

- West Virginia requires payors to report the names of all physicians with gold card status, as well as those whose status has been revoked, including the reasons for the revocation.

- Views on gold carding are mixed.[30] Some states have or are considering revisions to certain provisions in law; other states have commissioned pilot programs or studies to assess the impact of gold carding.
    - A West Virginia law enacted in 2020 was amended in 2023 to lower the approval threshold from 100 to 90 percent.
    - In 2023, Texas reported the impact of its law was "smaller than expected," with only three percent of providers receiving an exception for one or more services. Texas is exploring potential changes to the law.
    - A 2020 Vermont law required payors to implement pilot programs for modifying prior authorization requirements by January 1, 2022. Payors had flexibility in designing program requirements, including approval thresholds, durations for exemptions, and applicable drugs, items, and services. Payors were required to report findings by January 15, 2023. In general, lack of clear program requirements and guardrails led to the design of programs that were too narrow making it difficult for providers to qualify or determine eligibility to participate.[31]
    - A 2023 Rhode Island law required a workgroup consisting of providers and payors to make recommendations on approaches to reduce prior authorization volume, including the implementation of gold carding programs. A 2024 report included a recommendation that payors be required to reduce prior authorization volume by 20 percent with flexibility to decide how those reductions could be achieved.[32] The workgroup noted the need to maintain fairness, recommending payors assess rates of prior authorizations per member.
    - A 2023 Indiana law requires a pilot to exempt 49 commonly used CPT codes from prior authorization for state employee health plans and commissioned a study on the impact. A report is due to the legislature on November 1, 2025.

A CLOSER LOOK AT GOLD CARDING

Gold carding is designed to relax or eliminate prior authorization requirements for providers that have a track record of appropriate utilization and proper documentation.[33] Payors that adopt gold carding programs exempt providers that prescribe certain treatments and medications that follow evidence-

[30] AHIP, *2022 Industry Survey on Prior Authorization & Gold* Carding. Available at: ahiporg-production.s3.amazonaws.com/documents/2022-Prior-Auth-Survey-Results-FINAL.pdf.
[31] American Osteopathic Association, *Addressing Prior Authorization Related Care Barriers*. Available at: osteopathic.org/index.php?aam-media=/wp-content/uploads/Gold-Card-Program-White-Paper.pdf
[32] The recommendation states that reductions need to be in actual prior authorizations triggered, not just the number of services listed that require prior authorization (i.e., services eliminated could be very low volume and therefore rarely trigger prior authorization).
[33] Nair KV, Stuursma L, Eigenbrod M, Cremeen D, Ahmed A. Gold Carding Policies: Reducing the Barriers Between Payers and Providers. Neurol Clin Pract. 2024 Apr;14(2):e200256. doi: 10.1212/CPJ.0000000000200256. Epub 2024 Jan 10. PMID: 38223350; PMCID: PMC10783970.

based guidelines.[34] Some providers view exemptions as a potential alternative to address challenges associated with prior authorization. Gold carding approaches aim to improve access to timely care; however, program design and administration can present challenges (e.g., when a provider is no longer eligible and prior authorization must be completed).[35] Implementation requires payors to modify claims adjudication systems to bypass prior authorization processes.

UnitedHealthcare, one of the nation's largest insurers, voluntarily launched a gold carding program effective in all states October 1, 2024.[36] To qualify for gold card status, a provider must be in-network, have a minimum annual volume of at least 10 eligible prior authorizations for two consecutive years across eligible codes, and have a prior authorization approval rate of 92 percent or more. Other payers, such as Aetna and Cigna are seeking ways to automate the prior authorization process and reduce volume of drugs and services requiring prior authorization.[37]

Evidence on the impact and outcome of gold carding programs is limited. According to a 2022 study by America's Health Insurance Plan, gold carding programs are more effective when used selectively and continually reevaluated to ensure patients receive high-quality care.[38] The study also cited reasons gold carding programs are discontinued with the main reason being administrative difficulty, followed by concerns about reduced quality and patient safety, and higher costs without corresponding improvements in quality.[39]

ENHANCING AWARENESS OF DRUG COUPONS

Drug coupons (coupons) are incentives offered by pharmaceutical manufactures that encourage consumers to use brand medications, helping defray costs of prescription drugs.[40] Available coupons can initiate or continue a clinically necessary therapy that may otherwise be cost-prohibitive, helping enhance prescription adherence to improve health outcomes.[41] The conditions for using coupons vary. Some coupons are valid for only a single use or for a specific period after the initial fill; some may automatically renew or allow a discount for a certain number of fills.[42] The availability of coupons has increased over the last decade and are offered almost exclusively for more than 700 brand name

[34] American Medical Association, *7 Prior Authorization Terms that Drive Every Doctor to Distraction. American Medical Association*, November 13, 2023. Available at: www.ama-assn.org/practice-management/prior-authorization/7-prior-authorization-terms-drive-every-doctor-distraction.
[35] Vermon Agency of Human Services, *Report to the Vermont Legislation*, April 1, 2024. Available at: legislature.vermont.gov/assets/Legislative-Reports/DVHA-Gold-Carding-Report-Final.pdf.
[36] UnitedHealthcare News Room, *How the UnitedHealthcare Gold Card Program Helps Modernize Prior* Authorization, September 4, 2024. Available at: www.uhc.com/news-articles/newsroom/gold-card.
[37] Modern Healthcare, *Aetna seeks 'sweet spot' in plan to automate prior authorizations*, September 11, 2024. Available at: www.modernhealthcare.com/insurance/cvs-aetna-cathy-moffitt-prior-authorization-utilization-management.
[38] See n. 35, *Supra*.
[39] See n. 36, *Supra.*
[40] Congressional Research Service, *Prescription Drug Discount Coupons and Patient Assistance Programs,* September 12, 2022. Available at: crsreports.congress.gov/product/pdf/R/R44264.
[41] Commonwealth of Massachusetts Health Policy Commission, *Prescription Drug Coupon Study: Report to the Massachusetts, Legislature*, July 2020, available at: www.mass.gov/doc/prescription-drug-coupon-study/download.
[42] Jama Network, *Patterns of Manufacturer Coupon Ise for Prescription Drugs in the US, 2017-2019* (May 2023) available at: www.jamanetwork.com/journals/jamanetworkopen/fullarticle/2804994.

drugs.[43] Coupons are usually distributed in medical practices, pharmacies, pharmaceutical manufacturers websites, magazines, or mail.

Payors assert that coupons promote use of more expensive drugs even when cheaper alternatives are available.[44] This can increase spending on brand-name drugs by nearly 60 percent[45] when lower cost generics are available.[46] Research contends that coupons boost demand for high-priced brand-named drugs. While consumers who qualify for these coupons benefit, there use has also led to increased drug spending.[47] Generic drugs represent about 80 percent of the market yet contribute to only a small portion of the overall cost. Brand-name drugs, which make up the remaining 20 percent of the market, account for 80 percent of total drug spending.[48] Federal laws, such as the federal anti-kickback statute,[49] limit the use of coupons in federal health care programs. Similarly, private payers have made changes in drug plan benefit designs to limit their use for certain drugs or do not count the value of the coupon toward annual plan out-of-pocket spending requirements.[50]

IMPROVING PRIOR AUTHORIZATION WITH INTEROPERABILITY

Prior authorization processes are challenged by the lack of interoperability between payor and provider EHR systems; however, standards to establish interoperability are emerging.[51] Interoperability creates efficiencies in the secure exchange of information across multiple systems, enabling real-time access to patient-specific formulary and benefits information, alerting providers when prior authorization is required, and facilitating the completion of prior authorization requests during patient encounters. The CMS *Interoperability and Prior Authorization Final Rule* requires certain payors to implement and maintain a prior authorization API.[52] The API is designed to enable system connectivity to streamline the prior authorization process. In July 2024, the U.S. Department of Health and Human Services released the *Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability (HTI-2)* proposed rule[53] that includes several technology and standards requirements to enhance interoperability among systems. One of the most

[43] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Ensuring Patient Access to Affordable Drug Therapies; Nass SJ, Madhavan G, Augustine NR, editors. Making Medicines Affordable: A National Imperative. Washington (DC): National Academies Press (US); 2017 Nov 30. 3, Factors Influencing Affordability. Available from: www.ncbi.nlm.nih.gov/books/NBK493090/.
[44] See n. 42, *Supra*.
[45] Kang S, Liu A, Anderson G, Alexander GC. Patterns of Manufacturer Coupon Use for Prescription Drugs in the US, 2017-2019. JAMA Netw Open. 2023;6(5):e2313578. doi:10.1001/jamanetworkopen.2023.13578
[46] Availability of generic drugs provides competing products that are sold at a lower cost than the original branded product.
[47] National Bureau of Economic Research, *Copayment Coupons and the Pricing of Prescription Drugs*, May 2022. Available at: www.nber.org/digest/202205/copayment-coupons-and-pricing-prescription-drugs.
[48] ASPE, Office of Science & Data Policy, *Trends in Prescription Drug Spending, 2016-2021,* Issue Brief available at: www.aspe.hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf.
[49] Section 1128B(b) of the Social Security Act, *Criminal Penalties for Acts Involving Federal Health Care Programs,* available at: www.ssa.gov/OP_Home/ssact/title11/1128B.htm.
[50] See n. 49, *Supra.*
[51] See n. 8, *Supra*.
[52] *Ibid.*
[53] U.S. Department of Health and Human Services, *HHS Proposes HTI-2 Rule to Improve Patient Engagement, Information Sharing, and Public Health Interoperability*, July 10, 2024. Available at: www.hhs.gov/about/news/2024/07/10/hhs-proposes-hti-2-rule-improve-patient-engagement-information-sharing-public-health-interoperability.html.

significant benefits to be gained is the automatic filling of prior authorization forms with the necessary clinical information from the EHR.[54]

REAL-TIME BENEFIT TOOLS IN CLINICAL DECISION-MAKING

Providers typically view real-time benefit tools ("RTBTs") as effective clinical decision support. RTBTs provide up-to-date patient-specific formulary and benefit information, cost details, drug alternatives, and utilization management requirements at the point of care. Federal efforts to advance transparency using RTBTs are proceeding. In January 2023, Medicare Part D drug plans were required to offer a beneficiary access to patient-specific formulary and benefit information (i.e., cost, formulary alternatives, and utilization management requirements).[55] Plans may use an existing online portal, create a new portal, or implement an API to meet this requirement. The requirement builds on CMS's existing regulation that requires plans to adopt RTBTs that can integrate with at least one electronic prescribing or EHR system by January 2021.

Drawbacks of RTBTs can include inaccuracies in benefits information and prior authorization requirements, variability in functionality, and a lack of interoperability with EHRs.[56] Access to portals requires a separate login outside of the EHR system. These challenges frequently cause providers to manually submit prior authorization requests, which can lead to increased workload, administrative costs, and delays.[57] Overall, the use of RTBTs has produced mixed results in reducing the time and costs associated with prior authorizations.[58]

ADVERSE DECISION DATA INSIGHTS

Payors provide the MIA with quarterly reporting of adverse decisions (Insurance Article § 15-10A-06).[59] This information supports the MIA in their review of data on grievances and complaints. Pharmacy accounts for more than half of all adverse decisions reported to MIA (Table 1). Provider services and other service categories make up the remaining adverse decisions in Maryland.[60]

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[54] National Library of Medicine, *Electronic Prior Authorization for Prescription Drugs - Challenges and Opportunities for Reform*, March 2023. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC10880819/.

[55] CMS, *Changes to Medicare Advantage and Part D Will Provide Better Coverage, More Access and Improved Transparency for Medicare Beneficiaries,* January 2021. Available at: www.cms.gov/newsroom/press-releases/changes-medicare-advantage-and-part-d-will-provide-better-coverage-more-access-and-improved.

[56] National Library of Medicine, Lauffenburger JC, Stults CD, Mudiganti S, et al. *Impact of Implementing Electronic Prior Authorization On Medication Filling In An Electronic Health Record System In A Large Healthcare System*. Available at: www.pubmed.ncbi.nlm.nih.gov/34279657/.

[57] CoverMyMeds, *Electronic Prior Authorization*. CoverMyMeds (2020) available at: www.covermymeds.com/main/insights/scorecard/.

[58] National Library of Medicine, *Physician Perspectives on Implementation of Real-Time Benefit Tools: A Qualitative Study,* January 2022. Available at: www.pubmed.ncbi.nlm.nih.gov/36122592/.

[59] Also included is the number and outcome of any ensuing grievance filed appealing an adverse decision.

[60] Other service categories include inpatient hospital, emergency room, mental health, physician, laboratory, radiology, pharmacy, physical therapy, occupational therapy, specialty therapy, skilled nursing facility, durable medical equipment, dental, home health, obesity, in vitro fertilization, podiatry, hearing, and vision.

Table1:

Adverse Decisions Reported to the MIA – Pharmacy and Physician Services *2022 Maryland Snapshot, Select Payors*[61]					
Payor	**Total Adverse Decisions**	**Pharmacy**		**Physician Services**	
	#	*#*	*% of Adverse Decisions*	*#*	*% of Adverse Decisions*
Aetna Health, Inc.	116	0	0%	27	23%
Aetna Life Insurance Company	284	27	10%	94	33%
CareFirst BlueChoice, Inc.	25,416	19,065	75%	1,063	4%
CareFirst of Maryland, Inc.	9,684	8,004	83%	140	1%
Group Hospitalization and Medical Services, Inc.	7,604	6,344	83%	171	2%
CIGNA Health and Life Insurance Company	17,818	7,623	43%	867	5%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	1,432	11	1%	204	14%
Kaiser Permanente Insurance Company	42	0	0%	8	19%
MAMSI Life and Health Insurance Company	1,229	905	74%	134	11%
Optimum Choice, Inc.	3,056	2,122	69%	212	7%
UnitedHealthcare Insurance Company	16,264	6,032	37%	1,189	7%
UnitedHealthcare of the Mid-Atlantic, Inc.	3,833	2,416	63%	409	11%
Total	**86,662**	**52,549**	**61%**	**4,491**	**5%**

Adverse decisions increased around seven percent from 2019 to 2022; growth in pharmacy outpaces provider services for almost all payors (Table 2). Data to assess the share of adverse decisions as a percentage of total prior authorizations is not currently collected; however, Senate Bill 791/House Bill 932 will require payors, effective January 1, 2025, to include the number of adverse decisions that involved a prior authorization request or a step therapy protocol in their quarterly reports. By and

[61] More information on counts reported by all payors is available here: insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2022-Report-on-the-Health-Care-Appeals-and-Grievance-Law.pdf.

large, reporting requirements among states vary (see Appendix C for more information); key metrics collected include total number of prior authorization requests, denials, and approvals.

Table2:

Growth in Adverse Decisions *2019-2022, Select Payors*[62]			
Payor	**Growth Rate**		
	Total	***Pharmacy***	***Physician Services***
Aetna	-1%	-34%	-41%
CareFirst	5%	12%	10%
CIGNA	22%	59%	30%
Kaiser	21%	122%	8%
UnitedHealthcare	3%	14%	17%
Total	**7%**	**17%**	**9%**

PAYOR REPORTING - NEXT STEPS

In Q1 2025, MHCC will request payors submit an affirmation that they will meet the July 1, 2025 reporting requirements (Health-General Article § 19-108.5, Section 1 (C), see Appendix B). Among other things, the law requires payors to post on their website contact information of vendors used to support electronic prior authorizations. Payors unable to meet these requirements will be requested to submit an implementation plan detailing the steps they are taking to comply with the law. The MHCC will also request payors provide a timeline for implementing the July 1, 2026 requirements (Health-General Article § 19-108.5, Sections 1(D) and (E), see Appendix B) in Q4 2025. The requirements include integrating provider e-prescribing or EHR systems with payor prior authorization systems.

The MHCC will provide the legislature with an update on payor implementation of electronic prior authorization as required by law (December 1, 2025). The report will detail the status of payor compliance and include any findings and recommendations for legislative consideration.

[62] See Appendix A for adverse decision totals from 2019-2022. More information on totals for all payors is available here: insurance.maryland.gov/Consumer/Pages/AppealsAndGrievancesReports.aspx.

ACKNOWLEDGEMENTS

The MHCC and MIA appreciate the contributions of stakeholders that informed the development of this report. The diverse feedback received was valuable in shaping the MHCC and MIA's understanding of the issues and ensuring that the report reflects a broad range of perspectives. It is important to note that while stakeholders view the report as balanced, the findings and recommendations do not represent complete unanimity among all parties involved.

APPENDIX A – ADVERSE DECISIONS

Total Adverse Decisions by Payor, 2019-2022				
Payor	**2019**	**2020**	**2021**	**2022**
Aetna	415	251	808	400
CareFirst	37,146	34,595	33,700	42,704
CIGNA	9,824	9,382	17,081	17,818
Kaiser	839	668	873	1,474
UnitedHealthcare	22,003	21,416	20,469	24,382
Total	**70,227**	**66,312**	**72,931**	**86,778**

Note: See Table 2 above for information on growth rate.

Chapter 848 (Cross-filed with Chapter 847)

(Senate Bill 791) (Cross-filed with House Bill 932)

AN ACT concerning

Health Insurance – Utilization Review – Revisions

FOR the purpose of altering and establishing requirements and prohibitions related to health insurance utilization review; altering requirements related to internal grievance procedures and adverse decision procedures; altering certain reporting requirements on health insurance carriers relating to adverse decisions; establishing requirements on health insurance carriers and health care providers relating to the provision of patient benefit information; and generally relating to health insurance and utilization review.

BY adding to
Article – Health – General Section
19–108.5
Annotated Code of Maryland (2023
Replacement Volume)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–851 and 15–10B–01(a)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing and reenacting, with amendments, Article
– Insurance
Section 15–854 and 15–10B–06
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)
(As enacted by Chapters 364 and 365 of the Acts of the General Assembly of 2023)

BY adding to
Article – Insurance Section
15–854.1
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing and reenacting, with amendments, Article
– Insurance
Section 15–10A–01, 15–10A–02, 15–10A–04(c), 15–10A–06, 15–10A–08, 15–10B–01(b), 15–10B–02, 15–10B–05, 15–10B–07, and 15–10B–09.1
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–108.5.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "CARRIER" HAS THE MEANING STATED IN § 15–1301 OF THE INSURANCE ARTICLE.

(3) "HEALTH CARE PROVIDER" HAS THE MEANING STATED IN § 19–108.3 OF THIS SUBTITLE.

(B) (1) ON OR BEFORE JULY 1, 2026, A CARRIER SHALL ESTABLISH AND MAINTAIN AN ONLINE PROCESS THAT:

(I) LINKS DIRECTLY TO ALL E–PRESCRIBING SYSTEMS AND ELECTRONIC HEALTH RECORD SYSTEMS THAT USE THE NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS SCRIPT STANDARD AND THE NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS REAL TIME BENEFIT STANDARD;

(II) CAN ACCEPT ELECTRONIC PRIOR AUTHORIZATION REQUESTS FROM A HEALTH CARE PROVIDER;

(III) CAN APPROVE ELECTRONIC PRIOR AUTHORIZATION REQUESTS:

1. FOR WHICH NO ADDITIONAL INFORMATION IS NEEDED BY THE CARRIER TO PROCESS THE PRIOR AUTHORIZATION REQUEST;

2. FOR WHICH NO CLINICAL REVIEW IS REQUIRED; AND

3. THAT MEET THE CARRIER'S CRITERIA FOR APPROVAL; AND

(IV) LINKS DIRECTLY TO REAL–TIME PATIENT OUT–OF–POCKET COSTS, INCLUDING COPAYMENT, DEDUCTIBLE, AND COINSURANCE COSTS, AND MORE AFFORDABLE MEDICATION ALTERNATIVES MADE AVAILABLE BY THE CARRIER.

(2) A CARRIER MAY NOT:

(I) IMPOSE A FEE OR CHARGE ON A PERSON FOR ACCESSING THE ONLINE PROCESS REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION; OR

(II) ACCESS, WITHOUT HEALTH CARE PROVIDER CONSENT, HEALTH CARE PROVIDER DATA VIA THE ONLINE PROCESS OTHER THAN FOR THE INSURED OR ENROLLEE.

(C) ON OR BEFORE JULY 1, 2025, A CARRIER SHALL:

(1) ON REQUEST OF A HEALTH CARE PROVIDER, PROVIDE CONTACT INFORMATION FOR EACH THIRD–PARTY VENDOR OR OTHER ENTITY THAT THE CARRIER WILL USE TO MEET THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION; AND

(2) POST THE CONTACT INFORMATION REQUIRED TO BE PROVIDED UNDER ITEM (1) OF THIS SUBSECTION ON ITS WEBSITE.

(D) (1) ON OR BEFORE JULY 1, 2026, EACH HEALTH CARE PROVIDER SHALL ENSURE THAT EACH E–PRESCRIBING SYSTEM OR ELECTRONIC HEALTH RECORD SYSTEM OWNED OR CONTRACTED FOR BY THE HEALTH CARE PROVIDER TO MAINTAIN A HEALTH RECORD OF AN INSURED OR ENROLLEE HAS THE ABILITY TO ACCESS, AT THE POINT OF PRESCRIBING:

(I) THE ELECTRONIC PRIOR AUTHORIZATION PROCESS ESTABLISHED BY A CARRIER UNDER SUBSECTION (B) OF THIS SECTION; AND

(II) THE REAL–TIME PATIENT OUT–OF–POCKET COST INFORMATION AND AVAILABLE MEDICATION ALTERNATIVES REQUIRED UNDER SUBSECTION (B) OF THIS SECTION.

(2) THE COMMISSION SHALL ESTABLISH BY REGULATION A PROCESS THROUGH WHICH A HEALTH CARE PROVIDER MAY REQUEST AND RECEIVE A WAIVER OF COMPLIANCE FROM THE REQUIREMENTS OF THIS SUBSECTION.

(E) (1) ON OR BEFORE JULY 1, 2026, EACH CARRIER, OR A PHARMACY BENEFITS MANAGER ON BEHALF OF THE CARRIER, SHALL:

(I) PROVIDE REAL–TIME PATIENT–SPECIFIC BENEFIT INFORMATION TO INSUREDS AND ENROLLEES AND CONTRACTED HEALTH CARE PROVIDERS, INCLUDING ANY OUT–OF–POCKET COSTS AND MORE AFFORDABLE MEDICATION ALTERNATIVES OR PRIOR AUTHORIZATION REQUIREMENTS; AND

(II) ENSURE THAT THE INFORMATION PROVIDED UNDER ITEM (I) OF THIS PARAGRAPH IS ACCURATE.

(2) EACH CARRIER, OR A PHARMACY BENEFITS MANAGER ON BEHALF OF THE CARRIER, SHALL MAKE AVAILABLE THE INFORMATION REQUIRED TO BE PROVIDED UNDER PARAGRAPH (1) OF THIS SUBSECTION TO THE HEALTH CARE PROVIDER AT THE POINT OF PRESCRIBING IN AN ACCESSIBLE AND UNDERSTANDABLE FORMAT, SUCH AS THROUGH THE HEALTH CARE PROVIDER'S E–PRESCRIBING SYSTEM OR ELECTRONIC HEALTH RECORD SYSTEM THAT THE CARRIER, PHARMACY BENEFITS MANAGER, OR DESIGNATED SUBCONTRACTOR HAS ADOPTED THAT USES THE NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS SCRIPT STANDARD AND THE NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS REAL TIME BENEFIT STANDARD FROM WHICH THE HEALTH CARE PROVIDER MAKES THE REQUEST.

Article – Insurance

15–851.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for substance use disorder benefits or prescription drugs under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for substance use disorder benefits or prescription drugs under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for substance use disorder benefits under the medical benefit or for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(b) An entity subject to this section may not apply a prior authorization requirement for a prescription drug:

(1) when used for treatment of an opioid use disorder; and

(2) that contains methadone, buprenorphine, or naltrexone.

15–854.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs through a pharmacy benefit under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs through a pharmacy benefit under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager or that contracts with a private review agent under Subtitle 10B of this article is subject to the requirements of this section.

(3) This section does not apply to a managed care organization as defined in § 15–101 of the Health – General Article.

(b) (1) (i) If an entity subject to this section requires a prior authorization for a prescription drug, the prior authorization request shall allow a health care provider to indicate whether a prescription drug is to be used to treat a chronic condition.

(ii) If a health care provider indicates that the prescription drug is to treat a chronic condition, an entity subject to this section may not request a reauthorization for a repeat prescription for the prescription drug for 1 year or for the standard course of treatment for the chronic condition being treated, whichever is less.

(2) For a prior authorization that is filed electronically, the entity shall maintain a database that will prepopulate prior authorization requests with an insured's available insurance and demographic information.

(c) **[**If an entity subject to this section denies coverage for a prescription drug, the entity shall provide a detailed written explanation for the denial of coverage, including whether the denial was based on a requirement for prior authorization.

(d)**]** (1) On receipt of information documenting a prior authorization from the insured or from the insured's health care provider, an entity subject to this section shall honor a prior authorization granted to an insured from a previous entity for at least the **[**initial 30**] LESSER OF 90** days **[**of an insured's prescription drug benefit coverage under the health benefit plan of the new entity**] OR THE LENGTH OF THE COURSE OF TREATMENT**.

(2) During the time period described in paragraph (1) of this subsection, an entity may perform its own review to grant a prior authorization for the prescription drug.

[(e)**] (D)** (1) An entity subject to this section shall honor a prior authorization issued by the entity for a prescription drug **AND MAY NOT REQUIRE A HEALTH CARE**

PROVIDER TO SUBMIT A REQUEST FOR ANOTHER PRIOR AUTHORIZATION FOR THE PRESCRIPTION DRUG:

(i) if the insured changes health benefit plans that are both covered by the same entity and the prescription drug is a covered benefit under the current health benefit plan; or

(ii) except as provided in paragraph (2) of this subsection, when the dosage for the approved prescription drug changes and the change is consistent with federal Food and Drug Administration labeled dosages.

(2) **[**An**] EXCEPT AS PROVIDED IN § 15–851 OF THIS SUBTITLE, AN** entity may **[**not be required to honor**] REQUIRE** a prior authorization for a change in dosage for an opioid under this subsection.

[(f)**] (E) (1)** If an entity under this section implements a new prior authorization requirement for a prescription drug, the entity shall provide notice of the new requirement at least **[**30**] 60** days before the implementation of a new prior authorization requirement:

[(1)**] (I)** in writing to any insured who is prescribed the prescription drug; and

[(2)**] (II)** either in writing or electronically to all contracted health care providers.

(2) THE NOTICE REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL INDICATE THAT THE INSURED MAY REMAIN ON THE PRESCRIPTION DRUG AT THE TIME OF REAUTHORIZATION IN ACCORDANCE WITH SUBSECTION (G) OF THIS SECTION.

[(g)**] (F)** (1) Except as provided in paragraph (2) of this subsection, an entity subject to this section may not require more than one prior authorization if two or more tablets of different dosage strengths of the same prescription drug are:

(i) prescribed at the same time as part of an insured's treatment plan; and

(ii) manufactured by the same manufacturer.

(2) This subsection does not prohibit an entity from requiring more than one prior authorization if the prescription is for two or more tablets of different dosage strengths of an opioid that is not an opioid partial agonist.

(G) (1) ~~THIS SUBSECTION DOES NOT APPLY WITH RESPECT TO A REAUTHORIZATION OF A PRESCRIPTION DRUG REQUESTED BY A PROVIDER EMPLOYED BY A GROUP MODEL HEALTH MAINTENANCE ORGANIZATION, AS DEFINED IN § 19–713.6 OF THE HEALTH – GENERAL ARTICLE.~~

~~(2)~~ AN ENTITY SUBJECT TO THIS SECTION MAY NOT ISSUE AN ADVERSE DECISION ON A REAUTHORIZATION FOR THE SAME PRESCRIPTION DRUG OR REQUEST ADDITIONAL DOCUMENTATION FROM THE PRESCRIBER FOR THE REAUTHORIZATION REQUEST IF:

(I) THE PRESCRIPTION DRUG IS ~~A BIOLOGICAL PRODUCT USED FOR IMMUNOTHERAPY OR~~*:*

1. AN IMMUNE GLOBULIN (HUMAN) AS DEFINED IN 21 C.F.R. § 640.100; OR

***2. USED* FOR THE TREATMENT OF A MENTAL DISORDER LISTED IN THE MOST RECENT EDITION OF THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS PUBLISHED BY THE AMERICAN PSYCHIATRIC ASSOCIATION;**

~~(I)~~ (II) THE ENTITY PREVIOUSLY APPROVED A PRIOR AUTHORIZATION FOR THE PRESCRIPTION DRUG FOR THE INSURED;

~~(II)~~ (III) THE INSURED HAS BEEN TREATED WITH THE PRESCRIPTION DRUG WITHOUT INTERRUPTION SINCE THE INITIAL APPROVAL OF THE PRIOR AUTHORIZATION; AND

~~(III)~~ (IV) THE PRESCRIBER ATTESTS THAT, BASED ON THE PRESCRIBER'S PROFESSIONAL JUDGMENT, THE PRESCRIPTION DRUG CONTINUES TO BE NECESSARY TO EFFECTIVELY TREAT THE INSURED'S CONDITION.

~~(3)~~ *(2)* IF THE PRESCRIPTION DRUG THAT IS BEING REQUESTED HAS BEEN REMOVED FROM THE FORMULARY OR HAS BEEN MOVED TO A HIGHER DEDUCTIBLE, COPAYMENT, OR COINSURANCE TIER, THE ENTITY SHALL PROVIDE THE INSURED AND INSURED'S HEALTH CARE PROVIDER THE INFORMATION REQUIRED UNDER § 15–831 OF THIS SUBTITLE.

15–854.1.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "ACTIVE COURSE OF TREATMENT" MEANS A COURSE OF TREATMENT FOR WHICH AN INSURED IS ACTIVELY SEEING A HEALTH CARE PROVIDER AND FOLLOWING THE COURSE OF TREATMENT.

(3) "COURSE OF TREATMENT" MEANS TREATMENT THAT:

(I) IS PRESCRIBED TO TREAT OR ORDERED FOR THE TREATMENT OF AN INSURED WITH A SPECIFIC CONDITION;

(II) IS OUTLINED AND AGREED TO BY THE INSURED AND THE HEALTH CARE PROVIDER BEFORE THE TREATMENT BEGINS; AND

(III) MAY BE PART OF A TREATMENT PLAN.

(B) (1) THIS SECTION APPLIES TO:

(I) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS ON AN EXPENSE–INCURRED BASIS UNDER HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND

(II) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS UNDER CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.

(2) AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION THAT CONTRACTS WITH A PRIVATE REVIEW AGENT UNDER SUBTITLE 10B OF THIS TITLE IS SUBJECT TO THE REQUIREMENTS OF THIS SECTION.

(3) AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION THAT CONTRACTS WITH A THIRD PARTY TO DISPENSE MEDICAL DEVICES, MEDICAL APPLIANCES, OR MEDICAL GOODS FOR THE TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION IS SUBJECT TO THE REQUIREMENTS OF THIS SECTION.

(C) (1) NOTWITHSTANDING § 15–854 OF THIS SUBTITLE AS IT APPLIES TO COVERAGE FOR PRESCRIPTION DRUGS, AN ENTITY SUBJECT TO THIS SECTION SHALL APPROVE A REQUEST FOR THE PRIOR AUTHORIZATION OF A COURSE OF TREATMENT, INCLUDING FOR CHRONIC CONDITIONS, REHABILITATIVE SERVICES, SUBSTANCE USE DISORDERS, AND MENTAL HEALTH CONDITIONS, THAT IS:

(I) FOR A PERIOD OF TIME THAT IS AS LONG AS NECESSARY TO AVOID DISRUPTIONS IN CARE; AND

(II) DETERMINED IN ACCORDANCE WITH APPLICABLE COVERAGE CRITERIA, THE INSURED'S MEDICAL HISTORY, AND THE HEALTH CARE PROVIDER'S RECOMMENDATION.

(2) FOR NEW ENROLLEES, AN ENTITY SUBJECT TO THIS SECTION MAY NOT DISRUPT OR REQUIRE REAUTHORIZATION FOR AN ACTIVE COURSE OF TREATMENT FOR COVERED SERVICES FOR AT LEAST 90 DAYS AFTER THE DATE OF ENROLLMENT.

15–10A–01.

(a) In this subtitle the following words have the meanings indicated.

(b) (1) "Adverse decision" means:

(i) a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

1. a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and

2. may result in noncoverage of the health care service; or

(ii) a denial by a carrier of a request by a member for an alternative standard or a waiver of a standard to satisfy the requirements of a wellness program under § 15–509 of this title.

(2) "ADVERSE DECISION" INCLUDES A UTILIZATION REVIEW DETERMINATION BASED ON A PRIOR AUTHORIZATION OR STEP THERAPY REQUIREMENT.

[(2)**] (3)** "Adverse decision" does not include a decision concerning a subscriber's status as a member.

(c) "Carrier" means a person that offers a health benefit plan and is:

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization;

(5) a self–funded student health plan operated by an independent institution of higher education, as defined in § 10–101 of the Education Article, that provides health care to its students and their dependents; or

(6) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that provides health benefit plans subject to regulation by the State.

(d) "Complaint" means a protest filed with the Commissioner involving an adverse decision or grievance decision concerning the member.

(e) "Designee of the Commissioner" means any person to whom the Commissioner has delegated the authority to review and decide complaints filed under this subtitle, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

(f) "Grievance" means a protest filed by a member, a member's representative, or a health care provider on behalf of a member with a carrier through the carrier's internal grievance process regarding an adverse decision concerning the member.

(g) "Grievance decision" means a final determination by a carrier that arises from a grievance filed with the carrier under its internal grievance process regarding an adverse decision concerning a member.

(h) "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article.

(i) "Health benefit plan" has the meaning stated in § 2–112.2(a) of this article.

(j) "Health care provider" means:

(1) an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the member; or

(2) a hospital, as defined in § 19–301 of the Health – General Article.

(k) "Health care service" means a health or medical care procedure or service rendered by a health care provider that:

(1) provides testing, diagnosis, or treatment of a human disease or dysfunction; **[**or**]**

(2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction**; OR**

(3) PROVIDES ANY OTHER CARE, SERVICE, OR TREATMENT OF DISEASE OR INJURY, THE CORRECTION OF DEFECTS, OR THE MAINTENANCE OF PHYSICAL OR MENTAL WELL–BEING OF INDIVIDUALS.

(l) (1) "Member" means a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by a carrier.

(2) "Member" includes:

(i) a subscriber; and

(ii) unless preempted by federal law, a Medicare recipient.

(3) "Member" does not include a Medicaid recipient.

(m) "Member's representative" means an individual who has been authorized by the member to file a grievance or a complaint on the member's behalf.

(n) "Private review agent" has the meaning stated in § 15–10B–01 of this title.

15–10A–02.

(a) Each carrier shall establish an internal grievance process for its members.

(b) (1) An internal grievance process shall meet the same requirements established under Subtitle 10B of this title.

(2) In addition to the requirements of Subtitle 10B of this title, an internal grievance process established by a carrier under this section shall:

(i) include an expedited procedure for use in an emergency case for purposes of rendering a grievance decision within 24 hours of the date a grievance is filed with the carrier;

(ii) provide that a carrier render a final decision in writing on a grievance within 30 working days after the date on which the grievance is filed unless:

1. the grievance involves an emergency case under item (i) of this paragraph;

2. the member, the member's representative, or a health care provider filing a grievance on behalf of a member agrees in writing to an extension for a period of no longer than 30 working days; or

3. the grievance involves a retrospective denial under item (iv) of this paragraph;

(iii) allow a grievance to be filed on behalf of a member by a health care provider or the member's representative;

(iv) provide that a carrier render a final decision in writing on a grievance within 45 working days after the date on which the grievance is filed when the grievance involves a retrospective denial; and

(v) for a retrospective denial, allow a member, the member's representative, or a health care provider on behalf of a member to file a grievance for at least 180 days after the member receives an adverse decision.

(3) For purposes of using the expedited procedure for an emergency case that a carrier is required to include under paragraph (2)(i) of this subsection, the **[**Commissioner shall define by regulation the standards required for a grievance to be considered an emergency case**]** **CARRIER SHALL INITIATE THE EXPEDITED PROCEDURE FOR AN EMERGENCY CASE IF THE MEMBER OR THE MEMBER'S REPRESENTATIVE REQUESTS THE EXPEDITED REVIEW OR THE HEALTH CARE PROVIDER OR THE MEMBER OR THE MEMBER'S REPRESENTATIVE ATTESTS THAT:**

(I) THE ADVERSE DECISION WAS RENDERED FOR HEALTH CARE SERVICES THAT ARE PROPOSED BUT HAVE NOT BEEN PROVIDED; AND

(II) THE SERVICES ARE NECESSARY TO TREAT A CONDITION OR ILLNESS THAT, WITHOUT IMMEDIATE MEDICAL ATTENTION, WOULD:

1. SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTIONS;

2. CAUSE THE MEMBER TO BE IN DANGER TO SELF OR OTHERS; OR

3. CAUSE THE MEMBER TO CONTINUE USING INTOXICATING SUBSTANCES IN AN IMMINENTLY DANGEROUS MANNER.

(c) Except as provided in subsection (d) of this section, the carrier's internal grievance process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

(d) (1) (i) A member, the member's representative, or a health care provider filing a complaint on behalf of a member may file a complaint with the

Commissioner without first filing a grievance with a carrier and receiving a final decision on the grievance if:

1. the carrier waives the requirement that the carrier's internal grievance process be exhausted before filing a complaint with the Commissioner;

2. the carrier has failed to comply with any of the requirements of the internal grievance process as described in this section; or

3. the member, the member's representative, or the health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so.

(ii) The Commissioner shall define by regulation the standards that the Commissioner shall use to decide what demonstrates a compelling reason under subparagraph (i) of this paragraph.

(2) Subject to subsections (b)(2)(ii) and (h) of this section, a member, a member's representative, or a health care provider may file a complaint with the Commissioner if the member, the member's representative, or the health care provider does not receive a grievance decision from the carrier on or before the 30th working day on which the grievance is filed.

(3) Whenever the Commissioner receives a complaint under paragraph (1) or (2) of this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

(e) Each carrier shall:

(1) file for review with the Commissioner and submit to the Health Advocacy Unit a copy of its internal grievance process established under this subtitle; and

(2) file any revision to the internal grievance process with the Commissioner and the Health Advocacy Unit at least 30 days before its intended use.

(f) **(1)** For nonemergency cases, when a carrier renders an adverse decision, the carrier shall:

[(1)**]** **(I)** inform the member, the member's representative, or the health care provider acting on behalf of the member of the adverse decision:

[(i)**]** **1.** orally by telephone; or

[(ii)**]** **2.** with the affirmative consent of the member, the member's representative, or the health care provider acting on behalf of the member, by text, facsimile, e–mail, an online portal, or other expedited means; and

[(2)**]** **(II)** send, within 5 working days after the adverse decision has been made, a written notice to the member, the member's representative, and a health care provider acting on behalf of the member that:

[(i)**]** **1.** states in detail in clear, understandable language the specific factual bases for the carrier's decision **AND THE REASONING USED TO DETERMINE THAT THE HEALTH CARE SERVICE IS NOT MEDICALLY NECESSARY AND DID NOT MEET THE CARRIER'S CRITERIA AND STANDARDS USED IN CONDUCTING THE UTILIZATION REVIEW**;

[(ii)**]** **2.** **[**references**]** **PROVIDES** the specific **REFERENCE, LANGUAGE, OR REQUIREMENTS FROM THE** criteria and standards, including **ANY** interpretive guidelines, on which the decision was based, and may not solely use**:**

A. generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary"**; OR**

B. LANGUAGE DIRECTING THE MEMBER TO REVIEW THE ADDITIONAL COVERAGE CRITERIA IN THE MEMBER'S POLICY OR PLAN DOCUMENTS;

[(iii)**]** **3.** states the name, business address, and business telephone number of:

[1.**]** **A. IF THE CARRIER IS A HEALTH MAINTENANCE ORGANIZATION,** the medical director or associate medical director, as appropriate, who made the decision **[**if the carrier is a health maintenance organization**]**; or

[2.**]** **B. IF THE CARRIER IS NOT A HEALTH MAINTENANCE ORGANIZATION,** the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process **[**if the carrier is not a health maintenance organization**]** **AND THE PHYSICIAN WHO IS REQUIRED TO MAKE ALL ADVERSE DECISIONS AS REQUIRED IN § 15–10B–07(A) OF THIS TITLE**;

[(iv)**]** **4.** gives written details of the carrier's internal grievance process and procedures under this subtitle; and

[(v)**]** **5.** includes the following information:

[1.**] A.** that the member, the member's representative, or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision;

[2.**] B.** that a complaint may be filed without first filing a grievance if the member, the member's representative, or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so as determined by the Commissioner;

[3.**] C.** the Commissioner's address, telephone number, and facsimile number;

[4.**] D.** a statement that the Health Advocacy Unit is available to assist the member or the member's representative in both mediating and filing a grievance under the carrier's internal grievance process; and

[5.**] E.** the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(2) THE BUSINESS TELEPHONE NUMBER INCLUDED IN THE NOTICE AS REQUIRED UNDER PARAGRAPH (1)(II)3 OF THIS SUBSECTION MUST BE A DEDICATED NUMBER FOR ADVERSE DECISIONS AND MAY NOT BE THE GENERAL CUSTOMER CALL NUMBER FOR THE CARRIER.

(g) If within 5 working days after a member, the member's representative, or a health care provider, who has filed a grievance on behalf of a member, files a grievance with the carrier, and if the carrier does not have sufficient information to complete its internal grievance process, the carrier shall:

(1) **AFTER CONFIRMING THROUGH A COMPLETE REVIEW OF ANY INFORMATION ALREADY SUBMITTED BY THE HEALTH CARE PROVIDER:**

(I) notify the member, the member's representative, or the health care provider that it cannot proceed with reviewing the grievance unless additional information is provided**;**

(II) REQUEST THE SPECIFIC INFORMATION, INCLUDING ANY LAB OR DIAGNOSTIC TEST OR OTHER MEDICAL INFORMATION THAT MUST BE SUBMITTED TO COMPLETE THE INTERNAL GRIEVANCE PROCESS; AND

(III) PROVIDE THE SPECIFIC REFERENCE, LANGUAGE, OR REQUIREMENTS FROM THE CRITERIA AND STANDARDS USED BY THE CARRIER TO SUPPORT THE NEED FOR THE ADDITIONAL INFORMATION; and

(2) assist the member, the member's representative, or the health care provider in gathering the necessary information without further delay.

(h) A carrier may extend the 30–day or 45–day period required for making a final grievance decision under subsection (b)(2)(ii) of this section with the written consent of the member, the member's representative, or the health care provider who filed the grievance on behalf of the member.

(i) (1) For nonemergency cases, when a carrier renders a grievance decision, the carrier shall:

(i) document the grievance decision in writing after the carrier has provided oral communication of the decision to the member, the member's representative, or the health care provider acting on behalf of the member; and

(ii) send, within 5 working days after the grievance decision has been made, a written notice to the member, the member's representative, and a health care provider acting on behalf of the member that:

1. states in detail in clear, understandable language the specific factual bases for the carrier's decision **AND THE REASONING USED TO DETERMINE THAT THE HEALTH CARE SERVICE IS NOT MEDICALLY NECESSARY AND DID NOT MEET THE CARRIER'S CRITERIA AND STANDARDS USED IN CONDUCTING UTILIZATION REVIEW**;

2. **[**references**]** **PROVIDES** the specific **REFERENCE, LANGUAGE, OR REQUIREMENTS FROM THE** criteria and standards, including **ANY** interpretive guidelines **USED BY THE CARRIER**, on which the grievance decision was based;

3. states the name, business address, and business telephone number of:

A. **IF THE CARRIER IS A HEALTH MAINTENANCE ORGANIZATION,** the medical director or associate medical director, as appropriate, who made the grievance decision; or

B. **IF THE CARRIER IS NOT A HEALTH MAINTENANCE ORGANIZATION,** the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process **[**if the carrier is not a health maintenance organization**]** **AND THE DESIGNATED EMPLOYEE OR REPRESENTATIVE'S TITLE AND CLINICAL SPECIALTY**; and

4. includes the following information:

A. that the member or the member's representative has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision;

B. the Commissioner's address, telephone number, and facsimile number;

C. a statement that the Health Advocacy Unit is available to assist the member or the member's representative in filing a complaint with the Commissioner; and

D. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(2) THE BUSINESS TELEPHONE NUMBER INCLUDED IN THE NOTICE AS REQUIRED UNDER PARAGRAPH (1)(II)3 OF THIS SUBSECTION MUST BE A DEDICATED NUMBER FOR GRIEVANCE DECISIONS AND MAY NOT BE THE GENERAL CUSTOMER CALL NUMBER FOR THE CARRIER.

[(2)**] (3) [**A**] TO SATISFY THE REQUIREMENTS OF THIS SUBSECTION,** A carrier may not use solely in **[**a**] THE WRITTEN** notice sent under paragraph (1) of this subsection**:**

(I) generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary" **[**to satisfy the requirements of this subsection**]; OR**

(II) LANGUAGE DIRECTING THE MEMBER TO REVIEW THE ADDITIONAL COVERAGE CRITERIA IN THE MEMBER'S POLICY OR PLAN DOCUMENTS.

(j) (1) For an emergency case under subsection (b)(2)(i) of this section, within 1 day after a decision has been orally communicated to the member, the member's representative, or the health care provider, the carrier shall send notice in writing of any adverse decision or grievance decision to:

(i) the member and the member's representative, if any; and

(ii) if the grievance was filed on behalf of the member under subsection (b)(2)(iii) of this section, the health care provider.

(2) A notice required to be sent under paragraph (1) of this subsection shall include the following:

(i) for an adverse decision, the information required under subsection (f) of this section; and

(ii) for a grievance decision, the information required under subsection (i) of this section.

(k) (1) Each carrier shall include the information required by subsection **[**(f)(2)(iii), (iv), and (v)**]** **(F)(1)(II)3, 4, AND 5** of this section in the policy, plan, certificate, enrollment materials, or other evidence of coverage that the carrier provides to a member at the time of the member's initial coverage or renewal of coverage.

(2) Each carrier shall include as part of the information required by paragraph (1) of this subsection a statement indicating that, when filing a complaint with the Commissioner, the member or the member's representative will be required to authorize the release of any medical records of the member that may be required to be reviewed for the purpose of reaching a decision on the complaint.

(l) (1) Nothing in this subtitle prohibits a carrier from delegating its internal grievance process to a private review agent that has a certificate issued under Subtitle 10B of this title and is acting on behalf of the carrier.

(2) If a carrier delegates its internal grievance process to a private review agent, the carrier shall be:

(i) bound by the grievance decision made by the private review agent acting on behalf of the carrier; and

(ii) responsible for a violation of any provision of this subtitle regardless of the delegation made by the carrier under paragraph (1) of this subsection.

15–10A–04.

(c) (1) It is a violation of this subtitle for a carrier to fail to fulfill the carrier's obligations to provide or reimburse for health care services specified in the carrier's policies or contracts with members.

(2) If, in rendering an adverse decision or grievance decision, a carrier fails to fulfill the carrier's obligations to provide or reimburse for health care services specified in the carrier's policies or contracts with members, the Commissioner may:

(i) issue an administrative order that requires the carrier to:

1. cease inappropriate conduct or practices by the carrier or any of the personnel employed or associated with the carrier;

2. fulfill the carrier's contractual obligations;

3. provide a health care service or payment that has been denied improperly; or

4. take appropriate steps to restore the carrier's ability to provide a health care service or payment that is provided under a contract; or

(ii) impose any penalty or fine or take any action as authorized:

1. for an insurer, nonprofit health service plan, or dental plan organization, under this article; or

2. for a health maintenance organization, under the Health – General Article or under this article.

(3) In addition to paragraph (1) of this subsection, it is a violation of this subtitle, if the Commissioner, in consultation with an independent review organization, medical expert, the Department, or other appropriate entity, determines that the criteria and standards used by a health maintenance organization to conduct utilization review are not**[**:

(i) objective;

(ii) clinically valid;

(iii) compatible with established principles of health care; or

(iv) flexible enough to allow deviations from norms when justified on a case by case basis**]** **IN ACCORDANCE WITH ~~§ 15–10B–06~~ § 15–10B–05 OF THIS TITLE**.

15–10A–06.

(a) On **[**a quarterly**]** ~~AN ANNUAL~~ basis, each carrier shall submit to the Commissioner, on the form the Commissioner requires, a report that describes:

(1) the activities of the carrier under this subtitle, including:

(i) the outcome of each grievance filed with the carrier;

(ii) the number and outcomes of cases that were considered emergency cases under § 15–10A–02(b)(2)(i) of this subtitle;

(iii) the time within which the carrier made a grievance decision on each emergency case;

(iv) the time within which the carrier made a grievance decision on all other cases that were not considered emergency cases;

(v) the number of grievances filed with the carrier that resulted from an adverse decision involving length of stay for inpatient hospitalization as related to the medical procedure involved; **[**and**]**

(vi) the number of adverse decisions issued by the carrier under § 15–10A–02(f) of this subtitle**, ~~THE TYPE OF UTILIZATION REVIEW PROCESS USED, IF APPLICABLE,~~ WHETHER THE ADVERSE DECISION INVOLVED A PRIOR AUTHORIZATION OR STEP THERAPY PROTOCOL,** and the type of service at issue in the adverse decisions; **[**and**]**

~~(VII) THE TIME WITHIN WHICH THE CARRIER MADE THE ADVERSE DECISIONS UNDER EACH TYPE OF SERVICE AT ISSUE IN THE ADVERSE DECISIONS;~~

~~(VIII)~~ (VII) THE NUMBER OF ADVERSE DECISIONS OVERTURNED AFTER A RECONSIDERATION REQUEST UNDER § 15–10B–06 OF THIS TITLE; AND

~~(VIII)~~ (VIII) THE NUMBER OF REQUESTS MADE AND GRANTED UNDER § 15–831(C)(1) AND (2) OF THIS TITLE; AND

(2) the number and outcome of all other cases that are not subject to activities of the carrier under this subtitle that resulted from an adverse decision involving the length of stay for inpatient hospitalization as related to the medical procedure involved.

(b) The Commissioner shall:

(1) compile an annual summary report based on the information provided:

(i) under subsection (a) of this section; and

(ii) by the Secretary under § 19–705.2(e) of the Health – General Article; **[**and**]**

(2) REPORT ANY VIOLATIONS OR ACTIONS TAKEN UNDER § 15–10B–11 OF THIS TITLE; AND

[(2)**]** **(3)** provide copies of the summary report to the Governor and, subject to § 2–1257 of the State Government Article, to the General Assembly.

15–10A–08.

(a) On or before November 1, 1999, and each November 1 thereafter, the Health Advocacy Unit shall publish an annual summary report and provide copies of the report to the Governor and, subject to § 2–1257 of the State Government Article, the General Assembly.

(b) (1) The annual summary report required under subsection (a) of this section shall be on the grievances and complaints filed with or referred to a carrier, the Commissioner, the Health Advocacy Unit, or any other federal or State government agency or unit under this subtitle during the previous fiscal year.

(2) In consultation with the Commissioner and any affected State government agency or unit, the Health Advocacy Unit shall:

(i) evaluate the effectiveness of the internal grievance process and complaint process available to members; and

(ii) include in the annual summary report the results of the evaluation and any proposed changes **TO THE LAW** that it considers necessary **TO ENSURE COMPLIANCE WITH THE PURPOSES OF THE LAW**.

15–10B–01.

(a) In this subtitle the following words have the meanings indicated.

(b) (1) "Adverse decision" means a utilization review determination made by a private review agent that a proposed or delivered health care service:

(i) is or was not medically necessary, appropriate, or efficient; and

(ii) may result in noncoverage of the health care service.

(2) "ADVERSE DECISION" INCLUDES A UTILIZATION REVIEW DETERMINATION BASED ON A PRIOR AUTHORIZATION OR STEP THERAPY REQUIREMENT.

[(2)**] (3)** "Adverse decision" does not include a decision concerning a subscriber's status as a member.

15–10B–02.

The purpose of this subtitle is to:

(1) promote the delivery of quality health care in a cost effective manner **THAT ENSURES TIMELY ACCESS TO HEALTH CARE SERVICES**;

(2) foster greater coordination**, COMMUNICATION, AND TRANSPARENCY** between payors**, PATIENTS,** and providers conducting utilization review activities;

(3) protect patients, business, and providers by ensuring that private review agents are qualified to perform utilization review activities and to make informed decisions on the appropriateness of medical care; and

(4) ensure that private review agents maintain the confidentiality of medical records in accordance with applicable State and federal laws.

15–10B–05.

(a) In conjunction with the application, the private review agent shall submit information that the Commissioner requires including:

(1) a utilization review plan that includes:

(i) the specific criteria and standards to be used in conducting utilization review of proposed or delivered health care services;

(ii) those circumstances, if any, under which utilization review may be delegated to a hospital utilization review program; and

(iii) if applicable, any provisions by which patients~~,~~ **OR** physicians, ~~or~~ hospitals**, OR OTHER HEALTH CARE PROVIDERS** may seek reconsideration;

(2) the type and qualifications of the personnel either employed or under contract to perform the utilization review;

(3) a copy of the private review agent's internal grievance process if a carrier delegates its internal grievance process to the private review agent in accordance with § 15–10A–02(l) of this title;

(4) the procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and health care providers 7 days a week, 24 hours a day in this State;

(5) if applicable, the procedures and policies to ensure that a representative of the private review agent is accessible to health care providers to make all determinations on whether to authorize or certify an emergency inpatient admission, or an admission for residential crisis services as defined in § 15–840 of this title, for the treatment of a mental, emotional, or substance abuse disorder within 2 hours after receipt of the information necessary to make the determination;

(6) the policies and procedures to ensure that all applicable State and federal laws to protect the confidentiality of individual medical records are followed;

(7) a copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan;

(8) a list of the third party payors for which the private review agent is performing utilization review in this State;

(9) the policies and procedures to ensure that the private review agent has a formal program for the orientation and training of the personnel either employed or under contract to perform the utilization review;

(10) a list of the persons involved in establishing the specific criteria and standards to be used in conducting utilization review**, INCLUDING EACH PERSON'S BOARD CERTIFICATION OR PRACTICE SPECIALTY, LICENSURE CATEGORY, AND TITLE WITHIN THE PERSON'S ORGANIZATION**; and

(11) certification by the private review agent that the criteria and standards to be used in conducting utilization review are **GENERALLY RECOGNIZED BY HEALTH CARE PROVIDERS PRACTICING IN THE RELEVANT CLINICAL SPECIALTIES AND ARE**:

(i) objective;

(ii) clinically valid;

[(iii) compatible with established principles of health care; and

(iv) flexible enough to allow deviations from norms when justified on a case by case basis;**]**

(III) REFLECTED IN PUBLISHED PEER–REVIEWED SCIENTIFIC STUDIES AND MEDICAL LITERATURE;

(IV) DEVELOPED BY:

1. A NONPROFIT HEALTH CARE PROVIDER PROFESSIONAL MEDICAL OR CLINICAL SPECIALTY SOCIETY, INCLUDING THROUGH THE USE OF PATIENT PLACEMENT CRITERIA AND CLINICAL PRACTICE GUIDELINES; OR

2. FOR CRITERIA NOT WITHIN THE SCOPE OF A NONPROFIT HEALTH CARE PROVIDER PROFESSIONAL MEDICAL OR CLINICAL SPECIALTY SOCIETY, AN ORGANIZATION THAT WORKS DIRECTLY WITH HEALTH CARE PROVIDERS IN THE SAME SPECIALTY FOR THE DESIGNATED CRITERIA WHO ARE EMPLOYED OR ENGAGED WITHIN THE ORGANIZATION OR OUTSIDE THE ORGANIZATION TO DEVELOP THE CLINICAL CRITERIA, IF THE ORGANIZATION:

A. DOES NOT RECEIVE DIRECT PAYMENTS BASED ON THE OUTCOME OF THE UTILIZATION REVIEW; AND

B. DEMONSTRATES THAT ITS CLINICAL CRITERIA ARE CONSISTENT WITH CRITERIA AND STANDARDS GENERALLY RECOGNIZED BY HEALTH CARE PROVIDERS PRACTICING IN THE RELEVANT CLINICAL SPECIALTIES;

(V) RECOMMENDED BY FEDERAL AGENCIES;

(VI) APPROVED BY THE FEDERAL FOOD AND DRUG ADMINISTRATION AS PART OF DRUG LABELING;

(VI) TAKING INTO ACCOUNT THE NEEDS OF ATYPICAL PATIENT POPULATIONS AND DIAGNOSES, INCLUDING THE UNIQUE NEEDS OF CHILDREN AND ADOLESCENTS;

(VII) SUFFICIENTLY FLEXIBLE TO ALLOW DEVIATIONS FROM NORMS WHEN JUSTIFIED ON A CASE–BY–CASE BASIS, INCLUDING THE NEED TO USE AN OFF–LABEL PRESCRIPTION DRUG;

(VIII) ENSURING QUALITY OF CARE OF HEALTH CARE SERVICES;

(IX) REVIEWED, EVALUATED, AND UPDATED AT LEAST ANNUALLY AND AS NECESSARY TO REFLECT ANY CHANGES; AND

(X) IN COMPLIANCE WITH ANY OTHER CRITERIA AND STANDARDS REQUIRED FOR COVERAGE UNDER THIS TITLE, INCLUDING COMPLIANCE WITH § 15–802(D) OF THIS TITLE FOR THE TREATMENT OF SUBSTANCE USE DISORDERS.

(b) **[**On the written request of any person or health care facility, the**]** **THE** private review agent shall **[**provide 1 copy of**]:**

(1) POST ON ITS WEBSITE OR THE CARRIER'S WEBSITE the specific criteria and standards to be used in conducting utilization review of proposed or delivered services and any subsequent revisions, modifications, or additions to the specific criteria and standards to be used in conducting utilization review of proposed or delivered services **[**to the person or health care facility making the request**]; AND**

(2) ON THE REQUEST OF A PERSON, INCLUDING A HEALTH CARE FACILITY, PROVIDE A COPY OF THE INFORMATION SPECIFIED UNDER ITEM (1) OF THIS SUBSECTION TO THE PERSON MAKING THE REQUEST.

(c) The private review agent may charge a reasonable fee for a **HARD** copy of the specific criteria and standards or any subsequent revisions, modifications, or additions to the specific criteria to any person or health care facility requesting a copy under subsection **[**(b)**] (B)(2)** of this section.

(d) A private review agent shall advise the Commissioner, in writing, of a change in:

(1) ownership, medical director, or chief executive officer within 30 days of the date of the change;

(2) the name, address, or telephone number of the private review agent within 30 days of the date of the change; or

(3) the private review agent's scope of responsibility under a contract.

15–10B–06.

(a) (1) Except as **OTHERWISE** provided in **[**paragraph (4) of**]** this subsection, a private review agent shall:

(i) make all initial determinations on whether to authorize or certify a nonemergency course of treatment **OR HEALTH CARE SERVICE, INCLUDING PHARMACEUTICAL SERVICES NOT SUBMITTED ELECTRONICALLY,** for a patient within 2 working days after receipt of the information necessary to make the determination;

(ii) make all determinations on whether to authorize or certify an extended stay in a health care facility or additional health care services within 1 working day after receipt of the information necessary to make the determination; **[**and**]**

(III) MAKE ALL DETERMINATIONS TO AUTHORIZE OR CERTIFY A REQUEST FOR ADDITIONAL VISITS OR DAYS OF CARE SUBMITTED AS PART OF AN EXISTING COURSE OF TREATMENT OR TREATMENT PLAN WITHIN 1 WORKING DAY AFTER RECEIPT OF THE INFORMATION NECESSARY TO MAKE THE DETERMINATION; AND

[(iii)**] (IV)** promptly notify the health care provider of the determination.

(2) **[**If within 3 calendar days after**] AFTER** receipt of the initial request for health care services **AND CONFIRMING THROUGH A COMPLETE REVIEW OF INFORMATION ALREADY SUBMITTED BY THE HEALTH CARE PROVIDER, IF** the private review agent **DETERMINES THAT THE PRIVATE REVIEW AGENT** does not have sufficient information to make a determination, the private review agent shall **PROMPTLY, BUT NOT LATER THAN 3 CALENDAR DAYS AFTER RECEIPT OF THE INITIAL REQUEST,** inform the health care provider that additional information must be provided **BY SPECIFYING:**

(I) THE INFORMATION, INCLUDING ANY LAB OR DIAGNOSTIC TEST OR OTHER MEDICAL INFORMATION, THAT MUST BE SUBMITTED TO COMPLETE THE REQUEST; AND

(II) THE CRITERIA AND STANDARDS TO SUPPORT THE NEED FOR ADDITIONAL INFORMATION.

[(3)**] (B)** If a private review agent requires prior authorization for an emergency inpatient admission, or an admission for residential crisis services as defined in § 15–840 of this title, for the treatment of a mental, emotional, or substance abuse disorder, the private review agent shall:

[(i)**] (1)** make all determinations on whether to authorize or certify an inpatient admission, or an admission for residential crisis services as defined in § 15–840 of this title, within 2 hours after receipt of the information necessary to make the determination; **[**and**]**

(2) IF ADDITIONAL INFORMATION IS NEEDED, PROMPTLY REQUEST THE SPECIFIC INFORMATION NEEDED, INCLUDING ANY LAB OR DIAGNOSTIC TEST OR OTHER MEDICAL INFORMATION; AND

[(ii)**] (3)** promptly notify the health care provider of the determination.

[(4)**] (C) (1)** For a step therapy exception request submitted electronically in accordance with a process established under § 15–142(f) of this title or a prior authorization request submitted electronically for pharmaceutical services, a private review agent shall make a determination:

(i) in real time if:

1. no additional information is needed by the private review agent to process the request; and

2. the request meets the private review agent's criteria for approval; or

(ii) if a request is not approved **IN REAL TIME** under item (i) of this paragraph, within 1 **[**business**] WORKING** day after the private review agent receives all of the information necessary to make the determination.

(2) IF ADDITIONAL INFORMATION IS NEEDED TO MAKE A DETERMINATION AFTER CONFIRMING THROUGH A COMPLETE REVIEW OF THE INFORMATION ALREADY SUBMITTED BY THE HEALTH CARE PROVIDER, THE PRIVATE

REVIEW AGENT SHALL REQUEST THE INFORMATION PROMPTLY, BUT NOT LATER THAN 3 CALENDAR DAYS AFTER RECEIPT OF THE INITIAL REQUEST, BY SPECIFYING:

(I) THE INFORMATION, INCLUDING ANY LAB OR DIAGNOSTIC TEST OR OTHER MEDICAL INFORMATION, THAT MUST BE SUBMITTED TO COMPLETE THE REQUEST; AND

(II) THE CRITERIA AND STANDARDS TO SUPPORT THE NEED FOR THE ADDITIONAL INFORMATION.

(D) (1) (I) ~~A~~ EXCEPT AS PROVIDED IN SUBSECTIONS (G) AND (H) OF THIS SECTION, A PRIVATE REVIEW AGENT SHALL MAKE INITIAL DETERMINATIONS ON WHETHER TO AUTHORIZE OR CERTIFY AN EMERGENCY COURSE OF TREATMENT OR HEALTH CARE SERVICE FOR A MEMBER WITHIN 24 HOURS AFTER THE INITIAL REQUEST AFTER RECEIPT OF THE INFORMATION NECESSARY TO MAKE THE DETERMINATION.

(II) IF THE PRIVATE REVIEW AGENT DETERMINES THAT ADDITIONAL INFORMATION IS NEEDED AFTER CONFIRMING THROUGH A COMPLETE REVIEW OF THE INFORMATION ALREADY SUBMITTED BY THE HEALTH CARE PROVIDER, THE PRIVATE REVIEW AGENT SHALL:

1. PROMPTLY REQUEST THE SPECIFIC INFORMATION NEEDED, INCLUDING ANY LAB OR DIAGNOSTIC TEST OR OTHER MEDICAL INFORMATION; AND

2. PROMPTLY, BUT NOT LATER THAN 2 HOURS AFTER RECEIPT OF THE INFORMATION, NOTIFY THE HEALTH CARE PROVIDER OF AN AUTHORIZATION OR CERTIFICATION DETERMINATION WHEN MADE BY THE PRIVATE REVIEW AGENT.

(2) A PRIVATE REVIEW AGENT SHALL INITIATE THE EXPEDITED PROCEDURE FOR AN EMERGENCY CASE IF THE PATIENT OR THE PATIENT'S REPRESENTATIVE REQUESTS OR IF THE HEALTH CARE PROVIDER ATTESTS THAT THE SERVICES ARE NECESSARY TO TREAT A CONDITION OR ILLNESS THAT, WITHOUT IMMEDIATE MEDICAL ATTENTION, WOULD:

(I) SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTIONS;

(II) CAUSE THE MEMBER TO BE IN DANGER TO SELF OR OTHERS; OR

(III) CAUSE THE MEMBER TO CONTINUE USING INTOXICATING SUBSTANCES IN AN IMMINENTLY DANGEROUS MANNER.

(E) IF A PRIVATE REVIEW AGENT FAILS TO MAKE A DETERMINATION WITHIN THE TIME LIMITS REQUIRED UNDER THIS SECTION, THE REQUEST SHALL BE DEEMED APPROVED.

[(b)**] (F) (1)** If an initial determination is made by a private review agent not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, a private review agent **[**may**] SHALL** provide the health care provider the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed 24 hours of the health care provider seeking the reconsideration.

(4) IF THE PHYSICIAN IS UNABLE TO IMMEDIATELY SPEAK WITH THE HEALTH CARE PROVIDER SEEKING THE RECONSIDERATION, THE PHYSICIAN SHALL PROVIDE THE HEALTH CARE PROVIDER WITH THE FOLLOWING CONTACT INFORMATION FOR THE HEALTH CARE PROVIDER TO USE TO CONTACT THE PHYSICIAN:

(I) A DIRECT TELEPHONE NUMBER THAT IS NOT THE GENERAL CUSTOMER CALL NUMBER; OR

(II) A MONITORED E–MAIL ADDRESS THAT IS DEDICATED TO COMMUNICATION RELATED TO UTILIZATION REVIEW.

[(c)**] (G)** For emergency inpatient admissions, a private review agent may not render an adverse decision solely because the hospital did not notify the private review agent of the emergency admission within 24 hours or other prescribed period of time after that admission if the patient's medical condition prevented the hospital from determining:

(1) the patient's insurance status; and

(2) if applicable, the private review agent's emergency admission notification requirements.

[(d)**] (H)** (1) Subject to paragraph (2) of this subsection, a private review agent may not render an adverse decision as to an admission of a patient during the first 24 hours after admission when:

(i) the admission is based on a determination that the patient is in imminent danger to self or others;

(ii) the determination has been made by the patient's physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and

(iii) the hospital immediately notifies the private review agent of:

1. the admission of the patient; and

2. the reasons for the admission.

(2) A private review agent may not render an adverse decision as to an admission of a patient to a hospital for up to 72 hours, as determined to be medically necessary by the patient's treating physician, when:

(i) the admission is an involuntary admission under §§ 10–615 and 10–617(a) of the Health – General Article; and

(ii) the hospital immediately notifies the private review agent of:

1. the admission of the patient; and

2. the reasons for the admission.

[(e)**] (I)** (1) A private review agent that requires a health care provider to submit a treatment plan in order for the private review agent to conduct utilization review of proposed or delivered services for the treatment of a mental illness, emotional disorder, or a substance abuse disorder:

(i) shall accept:

1. the uniform treatment plan form adopted by the Commissioner under § 15–10B–03(d) of this subtitle as a properly submitted treatment plan form; or

2. if a service was provided in another state, a treatment plan form mandated by the state in which the service was provided; and

(ii) may not impose any requirement to:

1. modify the uniform treatment plan form or its content; or

2. submit additional treatment plan forms.

(2) A uniform treatment plan form submitted under the provisions of this subsection:

(i) shall be properly completed by the health care provider; and

(ii) may be submitted by electronic transfer.

15–10B–07.

(a) (1) Except as provided in paragraphs (2) and (3) of this subsection, all adverse decisions shall be made by a **LICENSED** physician, or a panel of other appropriate health care service reviewers with at least one physician on the panel**,** who is**:**

(I) board certified or eligible in the same specialty as the treatment under review**; AND**

(II) KNOWLEDGEABLE ABOUT THE REQUESTED HEALTH CARE SERVICE OR TREATMENT THROUGH ACTUAL CLINICAL EXPERIENCE.

(2) When the health care service under review is a mental health or substance abuse service, the adverse decision shall be made by a **LICENSED** physician, or a panel of other appropriate health care service reviewers with at least one **LICENSED** physician, selected by the private review agent who:

(i) is board certified or eligible in the same specialty as the treatment under review; or

(ii) is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

(3) When the health care service under review is a dental service, the adverse decision shall be made by a licensed dentist, or a panel of other appropriate health care service reviewers with at least one licensed dentist on the panel **WHO IS KNOWLEDGEABLE ABOUT THE REQUESTED HEALTH CARE SERVICE OR TREATMENT THROUGH ACTUAL CLINICAL EXPERIENCE**.

(b) All adverse decisions shall be made by a physician or a panel of other appropriate health care service reviewers who are not compensated by the private review agent in a manner that violates § 19–705.1 of the Health – General Article or that deters the delivery of medically appropriate care.

(c) Except as provided in subsection (d) of this section, if a course of treatment has been preauthorized or approved for a patient, a private review agent may not retrospectively render an adverse decision regarding the preauthorized or approved services delivered to that patient.

(d) A private review agent may retrospectively render an adverse decision regarding preauthorized or approved services delivered to a patient if:

(1) the information submitted to the private review agent regarding the services to be delivered to the patient was fraudulent or intentionally misrepresentative;

(2) critical information requested by the private review agent regarding services to be delivered to the patient was omitted such that the private review agent's determination would have been different had the agent known the critical information; or

(3) the planned course of treatment for the patient that was approved by the private review agent was not substantially followed by the provider.

(e) If a course of treatment has been preauthorized or approved for a patient, a private review agent may not revise or modify the specific criteria or standards used for the utilization review to make an adverse decision regarding the services delivered to that patient.

15–10B–09.1.

A grievance decision shall be made based on the professional judgment of:

(1) (i) a **LICENSED** physician who is board certified or eligible in the same specialty as the treatment under review **AND KNOWLEDGEABLE ABOUT THE REQUESTED HEALTH CARE SERVICE OR TREATMENT THROUGH ACTUAL CLINICAL EXPERIENCE**; or

(ii) a panel of other appropriate health care service reviewers with at least one **LICENSED** physician on the panel who is board certified or eligible in the same specialty as the treatment under review **AND KNOWLEDGEABLE ABOUT THE REQUESTED HEALTH CARE SERVICE OR TREATMENT THROUGH ACTUAL CLINICAL EXPERIENCE**;

(2) when the grievance decision involves a dental service, a licensed dentist, or a panel of appropriate health care service reviewers with at least one dentist on the panel who is a licensed dentist, who shall consult with a dentist who is board certified or eligible in the same specialty as the service under review **AND KNOWLEDGEABLE ABOUT THE REQUESTED HEALTH CARE SERVICE OR TREATMENT THROUGH ACTUAL CLINICAL EXPERIENCE**; or

(3) when the grievance decision involves a mental health or substance abuse service:

(i) a licensed physician who:

1. is board certified or eligible in the same specialty as the treatment under review; or

2. is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review; or

(ii) a panel of other appropriate health care service reviewers with at least one **LICENSED** physician, selected by the private review agent who:

1. is board certified or eligible in the same specialty as the treatment under review; or

2. is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Care Commission and the Maryland Insurance Administration, in consultation with health care practitioners and payors of health care services, jointly shall conduct a study on the development of standards for the implementation of payor programs to modify prior authorization requirements for prescription drugs, medical care, and other health care services based on health care practitioner–specific criteria.

(b) The study conducted under subsection (a) of this section shall include, through an examination of literature review and legislatively or voluntarily established programs that have been implemented or are being considered in other states, an analysis of:

(1) adjustments to payor prior authorization requirements based on a health care practitioner's:

(i) prior approval rates;

(ii) ordering and prescribing patterns; and

(iii) participation in a payor's two–sided incentive arrangement or a capitation program; and

(2) any other information or metrics necessary to implement the payor programs.

(c) On or before December 1, 2024, the Maryland Health Care Commission and the Maryland Insurance Administration jointly shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, with the findings and recommendations from the study, including recommendations for legislative initiatives necessary for the establishment of payor programs modifying prior authorization requirements based on health care practitioner–specific criteria.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Care Commission ~~and the Maryland Insurance Administration jointly shall establish a workgroup to~~, in consultation with the Maryland Insurance Administration, shall:

(1) ~~assess~~ monitor the progress toward implementing the requirements in § 19–108.5 of the Health – General Article, as enacted by Section 1 of this Act, including monitoring any federal or State developments relating to the requirements; and

(2) review issues or recommendations from other states that are implementing a real–time benefit requirement, including establishing a link at the point of prescribing for any available coupons.

(b) On or before December 1, 2025, the Maryland Health Care Commission ~~and the Maryland Insurance Administration jointly shall submit a report to~~ shall inform the General Assembly, in accordance with § 2–1257 of the State Government Article, ~~with~~ of any findings and recommendations ~~from the workgroup~~ relating to the implementation of § 19–108.5 of the Health – General Article, as enacted by Section 1 of this Act.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect January 1, 2025.

SECTION 5. AND BE IT FURTHER ENACTED, That, except as provided in Section 4 of this Act, this Act shall take effect July 1, 2024.

Approved by the Governor, May 16, 2024.

APPENDIX C – STATE LAWS

State Prior Authorization Laws *As of January 2024**												
State	**Electronic Prior Authorization**	**Response Times**	**PA Length**	**Retrospective Denials**	**Data Reporting**	**Clinical Criteria and Medical Necessity**	**Notice of New Requirements**	**Transparency**	**Qualifications of Reviewer**	**Exceptions**	**Gold Carding**	**Peer-to-Peer/ Appeal Process/Other**	**Total**
AL		x							x			x	**3**
AK		x		x					x				**3**
AR	x	x	x	x	X	x	x	x	x	x	x	x	**12**
AZ		x		x		x							**3**
CA	x	x			X	x		x	x			x	**7**
CO	x	x				x		x	x			x	**6**
CT			x	x						x			**3**
DE	x	x	x		x	x	x	x					**7**
DC	x	x	x	x	x	x	x	x	x	x		x	**11**
FL													**0**
GA	x	x	x		x	x			x	x			**7**
HI													**0**
ID		x		x									**2**
IL		x	x	x	x	x	x	x	x		x	x	**10**
IN	x	x		x	x		x	x		x		x	**8**
IA	x	x		x				x					**4**
KS		x										x	**2**
KY	x	x	x	x		x	x	x	x	x			**9**
LA		x	x	x	x	x	x	x	x	x	x	x	**11**
ME	x	x		x		x				x			**5**
MD	x	x	x	x	x	x	x	x	x	x		x	**11**

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State Prior Authorization Laws

*As of January 2024**

State	Electronic Prior Authorization	Response Times	PA Length	Retrospective Denials	Data Reporting	Clinical Criteria and Medical Necessity	Notice of New Requirements	Transparency	Qualifications of Reviewer	Exceptions	Gold Carding	Peer-to-Peer/ Appeal Process/Other	Total
MA	x	x				x		x					4
MI	x	x	x		x	x	x	x	x		x		9
MN	x	x	x	x	x		x	x	x				8
MS		x											1
MO		x		x		x		x	x			x	6
MT		x	x			x	x	x	x	x			7
NE						x			x			x	3
NH	x	x			x	x				x		x	6
NM	x	x			x								3
NJ	x	x	x	x	x	x	x	x	x			x	10
NY	x	x		x		x		x	x	x		x	8
NC		x		x				x	x			x	5
ND	x											x	2
NV		x										x	2
OH	x	x	x	x			x	x	x			x	8
OK						x							1
OR	x	x	x	x	x	x	x	x	x		x	x	11
PA	x	x		x		x	x	x	x			x	8
RI		x		x				x	x		x	x	6
SC													0
SD								x					1
TN	x	x	x	x	x	x	x	x	x	x	x	x	12
TX	x	x			x		x	x	x	x	x	x	9
UT				x	x		x		x				4

State Prior Authorization Laws

*As of January 2024**

State	Electronic Prior Authorization	Response Times	PA Length	Retrospective Denials	Data Reporting	Clinical Criteria and Medical Necessity	Notice of New Requirements	Transparency	Qualifications of Reviewer	Exceptions	Gold Carding	Peer-to-Peer/ Appeal Process/Other	Total
VT	x	x									x		**3**
VA	x	x	x	x				x		x		x	**7**
WA	x	x	x		x	x	x	x	x	x		x	**10**
WV	x	x			x	x		x	x	x	x	x	**9**
WI		x											**1**
WY													**0**
Total	**28**	**41**	**18**	**24**	**19**	**25**	**19**	**29**	**28**	**16**	**10**	**27**	

Source: American Medical Association, fixpriorauth.org/sites/default/files/2024-02/Updated%202024%20Prior%20Authorization%20State%20Law%20Chart.pdf

*****Maryland reflects legislation enacted on May 16, 2024

Maryland and contiguous states are highlighted in yellow

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Health Care
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