



Chapter 848/Senate Bill 791 and Chapter 847/House Bill 932, *Health Insurance - Utilization Review - Revisions (2024)*

*Findings and Recommendations on the Implementation of § 19-108.5
Health – General Article*

SEPTEMBER 18, 2025

Presentation Overview



- Utilization Management
- Maryland Law
- Implementation Progress
- National Policy Developments
- Recommendations

Framing the Discussion



- ▶ Prior authorization is a form of utilization management used to determine medical necessity before coverage is approved
 - Requirements for prior authorization vary across payors – from lists of services and medications, approval criteria, and supporting documentation
 - While it can be an important tool to ensure medical necessity, it can also impact patient access to care. Forty-eight percent of insured adults are now reporting that their plan has required prior authorization for their treatment in the past year, with two-thirds saying that it delayed access to care, most commonly for two weeks.*



*PAN Foundation Survey, 2024. Available from: [https://www.panfoundation.org/nearly-half-of-insured-adults-have-faced-prior-authorization-requirements-in-the-past-year/#:~:text=A%20recent%20national%20poll%20from,two%20weeks%20\(45%20percent\).](https://www.panfoundation.org/nearly-half-of-insured-adults-have-faced-prior-authorization-requirements-in-the-past-year/#:~:text=A%20recent%20national%20poll%20from,two%20weeks%20(45%20percent).)

Maryland Law



Chapter 848 (Senate Bill 791) and Chapter 847 (House Bill 932), *Health Insurance – Utilization Review – Revisions (2024)*

- ▶ Requires payors to implement an online process by July 1, 2026 that meets specified parameters (among other things*)
- ▶ The online process must:
 - Link to all e-prescribing and electronic health record (EHR) systems using data exchange standards**
 - Accept electronic prior authorization requests from a health care provider
 - Approve prior authorization requests when no additional information or clinical review is required, and that meet the payor’s criteria for approval
 - Link directly to real-time patient out-of-pocket costs (i.e., copayment, deductible, and coinsurance) and more affordable medication alternatives at the point of prescribing

* Includes several provisions pertaining to health insurance utilization review, internal grievance and adverse decision procedures, payor reporting on adverse decisions, and the provision of patient benefit information

** Includes the NCPDP SCRIPT Standard and the NCPDP Real Time Benefit Standard

Maryland Law *(continued...)*



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- ▶ Includes study and reporting provisions:
 - **2024** - MHCC and the Maryland Insurance Administration (MIA) conducted an environmental scan of the development of standards for modifying prior authorization requirements for prescription drugs, medical care, and other services, including state-level approaches
 - A findings and recommendations report was submitted to the General Assembly (November 21, 2024)
 - **2025** - MHCC in collaboration with the MIA must monitor progress towards implementing requirements for the online process, including federal or State developments
 - A findings and recommendations report is due to the General Assembly by December 1, 2025



Current Landscape



- ▶ Most pharmacies, payors, PBMs, and EHR vendors support electronic prior authorization
 - Nationally, manual methods are still common; about half of prior authorization requests are submitted using online portals, phone, fax, etc.
- ▶ Real-time benefit check tools are used by more than half of prescribers nationally and allow providers to obtain patient-specific information about prescription benefits, out-of-pocket costs, and prior authorization requirements at the point of prescribing
 - EHR vendors integrate with more than one vendor to increase the likelihood of retrieving benefit data regardless of a patient's insurance plan



Current Landscape *(continued...)*



- ▶ Functionality is emerging that links to available coupons and other discounts that may lower patients' out-of-pocket cost for prescriptions
 - Warrants further consideration of the potential for unintended consequences related to access, costs, patient consent, and other market dynamics
- ▶ Use of Artificial Intelligence (AI) is increasing to automate administrative tasks, improve accuracy, and inform decision-making
 - Concerns exist that use of AI could potentially override clinical judgment and deny coverage for care that is medically necessary

Implementation of the Online Process



Payors self-attested they will be compliant with all technical requirements for the online process by July 1, 2026; pharmacy benefits managers have the capability to provide real-time patient-specific benefit information, as required by the law.

Payor Implementation Status – Online Process <i>(as of July 2025)</i> Maryland Code, Health-General § 19-108.5					
Payor Third-party vendor(s) for the online process	Technical Requirements				
	Link to EHR and e-prescribing systems	Accept prior authorization requests	Approve prior authorization requests	Provide real-time patient out-of-pockets costs	Provide more affordable medication alternatives
Aetna CVS Caremark, Availity	Completed	Completed	Completed	Completed	Completed
CareFirst CVS Caremark	Completed	Completed	Completed	Completed	Completed
Cigna Surescripts, CoverMyMeds	In Progress	Completed	Completed	In Progress	In Progress
Kaiser Permanente MedImpact	Completed	Completed	Completed	Completed	Completed
UnitedHealthcare Surescripts, CoverMyMeds	Completed	Completed	Completed	Completed	Completed

Notes: “Completed” means the payor attested that the technical requirement has been implemented; “In Progress” means the payor attested that implementation of the technical requirement is underway.
 - Third-party vendor names and contact information are posted on payors’ websites; payor names hyperlinked above.
 PBMs use third-party vendors noted in parenthesis:
[CVS Caremark](#) (Surescripts, CoverMyMeds, Arrive Health); [Express Scripts](#) (Surescripts, CoverMyMeds, EviCore by Evernorth, ExpressPath); [MedImpact](#) (Surescripts, CoverMyMeds, CenterX); [OptumRX](#) (Surescripts, CoverMyMeds)



Policy Developments

Federal and State-Level

A Call to Action



JUNE 2025

- ▶ In response to growing concerns that prior authorization delays patient access to care, AHIP* in collaboration with the federal government, implemented an initiative that aims to improve access to care and reduce administrative burdens for patients and providers
- ▶ More than 50 payors have voluntarily pledged a commitment to:
 - Standardize electronic prior authorization
 - Reduce the scope of claims subject to prior authorization
 - Ensure continuity of care when patients change plans
 - Enhance communication and transparency on determinations
 - Expand real-time responses
 - Ensure medical review of non-approved requests

** AHIP (America's Health Insurance Plans) is a national trade association representing numerous payers*

Federal Rules



APRIL 2023: The Centers for Medicare & Medicaid Services (CMS) finalized a rule that requires Medicare Advantage plans to implement improvements to the prior authorization process in 2024

- ▶ Prior authorization requests must be reviewed by clinicians with relevant expertise and be valid for an entire course of approved treatment and during transitions to a new plan for at least 90 days
- ▶ Internal coverage criteria must be publicly available and based on current evidence in widely used treatment guidelines or clinical literature

JANUARY 2024: CMS finalized a rule that requires all federally regulated payors to implement technical and non-technical requirements, including delivering prior authorization decisions within specified timeframes, reporting certain metrics, providing reasons for a prior authorization denial, and requiring payors to connect to EHR systems via application programming interfaces (APIs)

- ▶ Applies to medical items and services, not prescription drugs
- ▶ Many payors are still in the early stages of implementing the APIs, with the process widely viewed as technically challenging
 - Must comply with non-technical provisions by January 1, 2026 and technical provisions (APIs) by January 1, 2027

See Appendix for more information on the Interoperability and Prior Authorization Final Rule



Federal Rules *(continued...)*

APRIL 2025: CMS finalized a rule that further strengthens protections for consumers enrolled in or seeking coverage from Medicare Advantage plans in 2026

- ▶ Restricts plans from reopening and modifying previously approved prior authorizations for inpatient hospital decisions
- ▶ Ensures the appeals process applies to any denial whether the decision is made before, during, or after care is received

State Laws



- ▶ Most states are advancing prior authorization reform
 - Viewed as essential to improve access to care, reduce administrative burden, and promote transparency

- ▶ Some legislative priorities center on:
 - Aligning use of APIs with federal standards and timelines January 2027 (CA, MN, OK, TN, WA)
 - Prohibiting the sole use of AI to deny, delay, or modify a health care service (AZ, CA, CO, IL, MD)
 - Exploring (“gold-carding”) programs that exempt certain providers from prior authorization requirements based on prior approval rates (typically $\geq 90\%$ over a set period) (AR, CO, GA, IL, LA, MI, NM, TX, WY, WV)
 - Promoting use of real-time benefit check tools at the point of prescribing (CO, CA, OH, MD, ME, TN, TX, VA)
 - Banning use of manufacturer coupons when generic drugs are available (MA, CA); restricting payors from using copay accumulator programs (over 20 states, including Maryland)



Recommendations



- 1. Encourage payors and PBMs to build provider awareness of electronic prior authorization and real-time benefit check tools. Initiatives should target providers and care teams involved in the prior authorization process, and at a minimum, offer technical guidance on accessing and using online real-time benefit check tools within existing workflows, while addressing the benefits and acknowledging potential limitations (MHCC in collaboration with the MIA).***

Rationale:

Expanding use of electronic prior authorization and real-time benefit check tools is essential to realizing the full value of the State-mandated online process. Awareness building efforts led by payors and PBMs will help providers and care teams embed prior authorization into workflows by utilizing existing technology systems and capabilities. This supports timely decision-making at the point of care and enables earlier identification of prior authorization requirements.



2. Update the legislature by December 1, 2026 and December 1, 2027 on post-implementation of the State-mandated online process (MHCC).

Rationale:

The MHCC plans to monitor progress in building awareness. Providing a post-implementation update to the legislature will offer a snapshot on payors' and PBMs' awareness building strategies and utilization of the State-mandated online process among providers and care teams. The progress update should address adoption of real-time benefit check tools, assess accuracy and completeness of the information exchanged, and identify any operational challenges. The information will be used to assess progress and identify future policy considerations for enhancing efficiency, transparency, and equitable access to care.



- 3. Explore regulatory and oversight approaches to require that payers make coverage criteria publicly accessible with a summary of all current evidence justifying each criterion based on widely used treatment guidelines or clinical literature. Consider regulatory authorities for PBMs in conducting drug utilization review (MHCC in collaboration with the MIA).*

Rationale:

Requiring payors to include high-quality supporting evidence strengthens transparency and aligns with federal standards for Medicare Advantage. Extending similar transparency requirements to PBMs in their drug utilization review processes ensures consistency across payors and PBMs. Transparency ensures medical necessity determinations are grounded in widely accepted treatment guidelines or high-quality clinical literature. It also empowers patients to make more informed decisions when choosing plans, improves predictability in care planning, supports more informed clinical workflows, and fosters accountability in how coverage policies are developed and applied.



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DRAFT

September 18, 2025

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ACTING CHAIR

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Commission Action

Staff proposes the Commission approve the draft 2025 report and recommendations as final

The End





Appendix



Online Process



- ▶ Prohibits payors from charging a fee for using the online process or accessing provider data via the online process without the provider's consent
- ▶ Requires payors to make available (on request of a health care provider and on its website) the contact information for each third-party vendor or other entity the payor will use to meet the requirement by July 1, 2025
- ▶ Requires payors and pharmacy benefits managers to provide accurate and real-time patient specific benefit information and make the information available at the point of prescribing by July 1, 2026
- ▶ Health care providers must ensure their e-prescribing or EHR system has the ability to access the online process; MHCC must establish by regulation a process through which a health care provider may request and receive a waiver of compliance



Federal Interoperability and Prior Authorization Final Rule *Non-Technical Provisions*

Category	Requirements/Details	Compliance Date
Decision Timelines	Standard requests: ≤ 7 calendar days; Expedited: ≤ 72 hours	January 1, 2026
Patient Notification	Inform patients (not just providers) of approval or denial, with clear denial reasons	2026–2027 depending on plan type
Public Reporting & Transparency	Prior auth metrics (volume, decisions, timeframes) must be publicly posted annually	Reporting begins 2026
Educational Resources	Plain-language materials for patients/providers on APIs, opt-in/opt-out instructions	By API launch (January 1, 2027)
Appeals Transparency	Reason for denial must be consistently communicated via any channel	January 1, 2026

Source: www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

Federal Policy *(continued...)*



Federal Interoperability and Prior Authorization Final Rule *Technical Provisions*

Patient Access API: Expands the set of data payers must make available to members via the Patient Access API that was implemented for CMS-9115-F to now include information about prior authorization status and decisions

Provider Access API: Payers are required to share data about members, including information about prior authorization status and decisions, with in-network treating providers at the request of the provider if the member does not opt out

Payer-to-Payer API: Requires data sharing via a FHIR Payer-to-Payer API, including prior authorization information to facilitate care coordination, between one payer and other payers covering that member, if the member opts in, when an individual changes payers, or has concurrent coverage.

Prior Authorization API: Mandates adoption of electronic prior authorization processes using a Prior Authorization API and requires authorization decisions within narrow windows, and public reporting of metrics about authorizations.

Source: www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f