L.D. 796

Date: (Filing No. H- )

**HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES**

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**STATE OF MAINE**

**HOUSE OF REPRESENTATIVES**

**131ST LEGISLATURE**

**SECOND REGULAR SESSION**

COMMITTEE AMENDMENT " " to H.P. 485, L.D. 796, "An Act Concerning Prior Authorizations for Health Care Provider Services"

Amend the bill by striking out everything after the enacting clause and inserting the following:

'**Sec. 1. 24-A MRSA §4302, sub-§2,** as amended by PL 2007, c. 199, Pt. B, §3, is further amended to read:

**2. Plan ~~complaint;~~ complaints and adverse decisions~~; prior authorization~~ statistics.** A carrier shall provide annually to the superintendent information for each health plan that it offers or renews on plan complaints~~,~~ and adverse decisions ~~and prior authorization~~ statistics. This statistical information must contain, at a minimum:

A. The ratio of the number of complaints received by the plan to the total number of enrollees, reported by type of complaint and category of enrollee;

B. The ratio of the number of adverse decisions issued by the plan to the number of complaints received, reported by category;

~~C. The ratio of the number of prior authorizations denied by the plan to the number of prior authorizations requested, reported by category;~~

D. The ratio of the number of successful enrollee appeals overturning the original denial to the total number of appeals filed;

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; and

F. Enrollee satisfaction statistics, including provider-to-enrollee ratio by geographic region and medical specialty and a report on what actions, if any, the carrier has taken to improve complaint handling and eliminate the causes of valid complaints.

**Sec. 2. 24-A MRSA §4302, sub-§2-A** is enacted to read:

**2-A. Reporting of information related to prior authorization.** In addition to the information required to be provided under subsection 2, a carrier shall report to the superintendent the following information consistent with federal requirements for reporting of metrics related to prior authorization determinations for the prior calendar year, excluding data on prescription drugs:

A. A list of all items and services that require prior authorization;

B. The number and percentage of standard prior authorization requests that were approved, aggregated for all items and services;

C. The number and percentage of standard prior authorization requests that were denied, aggregated for all items and services;

D. The number and percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services;

E. The number and percentage of prior authorization requests for which the time frame for review was extended, and the request was approved, aggregated for all items and services;

F. The number and percentage of expedited prior authorization requests that were approved, aggregated for all items and services;

G. The number and percentage of expedited prior authorization requests that were denied, aggregated for all items and services;

H. The average and median time that elapsed between the submission of a request and a determination by the carrier, for standard prior authorizations, aggregated for all items and services; and

I. The average and median time that elapsed between the submission of a request and a decision by the carrier for expedited prior authorizations, aggregated for all items and services.

**Sec. 3. 24-A MRSA §4302, sub-§2-B** is enacted to read:

**2-B. Data reporting; utilization review data.** Beginning April 1, 2026 and annually thereafter, the superintendent shall collect the information required under subsections 2 and 2-A, together with the utilization review information collected pursuant to section 2749.

**Sec. 4. Stakeholder group on prior authorization requirements.** The Department of Professional and Financial Regulation, Bureau of Insurance shall convene a stakeholder group that includes representatives of physicians, hospitals, consumers, employers subject to state regulation, pharmacy benefit managers and health insurance carriers to consider the impact of prior authorization requirements on providers, enrollees and health care costs and outcomes. The Bureau of Insurance shall submit a report summarizing its findings no later than January 15, 2025 to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters. The committee may report out a bill related to findings in the report to the 132nd Legislature in 2025.'

Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

## SUMMARY

This amendment, which is the minority report of the committee, replaces the bill, which is a concept draft. The amendment requires carriers to report to the Department of Professional and Financial Regulation, Bureau of Insurance certain information related to prior authorization determinations consistent with federal requirements beginning April 1, 2026 and annually thereafter.

The amendment also requires the Bureau of Insurance to convene a stakeholder group to consider the impact of prior authorization requirements on providers, enrollees and health care costs and report back to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services by January 15, 2025. The committee may report out a bill related to any findings in the report to the 132nd Legislature in 2025.

**FISCAL NOTE REQUIRED**

**(See attached)**