L.D. 796

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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:

'**PART A**

Sec. A-1. 24-A MRSA §4301-A, sub-§1, as amended by PL 2011, c. 364, §20, is further amended to read:

1. Adverse health care treatment decision. "Adverse health care treatment decision" means a health care treatment decision made by or on behalf of a carrier offering or renewing a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee. "Adverse health care treatment decision" includes a rescission determination and an initial coverage eligibility determination, consistent with the requirements of the federal Affordable Care Act, and a prior authorization determination in accordance with section 4304.

Sec. A-2. 24-A MRSA §4301-A, sub-§2, as enacted by PL 1999, c. 742, §3, is amended to read:

2. Authorized representative. "Authorized representative" means:

A. A person to whom an enrollee has given express written consent to represent the enrollee in an external review;

B. A person authorized by law to provide consent to request an external review for an enrollee; ~~or~~

C. A family member of an enrollee or an enrollee's treating health care provider when the enrollee is unable to provide consent to request an external review~~.~~; or

D. A provider that is actively treating an enrollee.

Sec. A-3. 24-A MRSA §4303, sub-§4, as amended by PL 2019, c. 5, Pt. A, §20, is further amended to read:

4. Grievance procedure for enrollees. A carrier offering or renewing a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials, prior authorization denials or other matters by which enrollees are aggrieved.

A. The grievance procedure must include, at a minimum, the following:

(1) Notice to the enrollee and the enrollee's provider promptly of any claim denial, prior authorization denial or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a grievance, the procedure for doing so and the time period in which the grievance must be filed;

(2) Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly. Decisions for second level grievance reviews as defined by bureau rules must be issued within 30 calendar days if the insured has not requested the opportunity to appear in person before authorized representatives of the health carrier;

(3) Procedures for the submission of relevant information and enrollee or provider participation;

(4) Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal or external review rights, the procedure and time limitations for exercising those rights and notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; ~~and~~

(5) Decision-making by one or more individuals not previously involved in making the decision subject to the grievance~~.~~; and

(6) Procedures for a provider actively treating an enrollee to act as an authorized representative of the enrollee within the meaning of section 4301-A subsection 2, paragraph D and file a grievance on the enrollee's behalf as long as the provider notifies the enrollee in writing at least 14 days prior to filing a grievance and within 7 days after filing a grievance or withdrawing a grievance. The enrollee has the right to affirmatively object to a provider that has filed a grievance at any time, and the enrollee has the right to notify the health carrier at any time that the enrollee intends to take the place of the provider as a party to the grievance.

B. In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, the aggrieved party is entitled to an independent 2nd opinion, paid for by the plan, of a provider of the same specialty participating in the plan. If a provider of the same specialty does not participate in the plan, then the 2nd opinion must be given by a nonparticipating provider.

C. In any appeal under the grievance procedure, the carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is

visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection.

D. Notwithstanding this subsection, a group health plan sponsored by an agricultural cooperative association located outside of this State that provides health insurance coverage to members of one or more agricultural cooperative associations located within this State may employ a grievance procedure for enrollees in the group health plan that meets the requirements of the state in which the group health plan is located if enrollees in the group health plan that reside in this State have the right to independent external review in accordance with section 4312 following any adverse health care treatment decision. Any difference in the grievance procedure requirements between those of the state in which the group health plan is located and those of this State must be limited to the number of days required for notification of prior authorization for nonemergency services and the number of days required for the issuance of a decision following the filing of an appeal of an adverse health care treatment decision. Enrollees in the group health plan that reside in this State must be notified as to the grievance procedure used by the group health plan and their right to independent external review in accordance with section 4312.

E. Health plans may not reduce or terminate benefits for an ongoing course of treatment, including coverage of a prescription drug, during the course of an appeal pursuant to the grievance procedure used by the carrier or any independent external review in accordance with section 4312.

Sec. A-4. 24-A MRSA §4304, sub-§2, ¶E is enacted to read:

E. If a covered medically necessary service cannot be delivered on the approved date of an approved prior authorization request, a carrier may not deny the claim if the covered medically necessary service is provided within 14 days before or after the approved date.

Sec. A-5. 24-A MRSA §4304, sub-§2, ¶F is enacted to read:

F. For nonemergency services provided without a required prior authorization approval, a carrier may not deny a claim for nonemergency services that were within the scope of the enrollee's coverage pending medical necessity review and may not impose a penalty on the provider for failing to obtain a prior authorization of greater than 15% of the contractually allowed amount for the services that required prior authorization approval.

Sec. A-6. 24-A MRSA §4304, sub-§5, ¶B is enacted to read:

B. The medical necessity of emergency services may not be based on whether those services were provided by participating or nonparticipating providers. Restrictions on coverage of emergency services provided by nonparticipating providers may not be greater than restrictions that apply when those services are provided by participating providers.

Sec. A-7. 24-A MRSA §4304, sub-§5, ¶C is enacted to read:

C. If an enrollee receives an emergency service that requires immediate post-evaluation or post-stabilization services, a carrier may not require prior authorization for the post-evaluation or post-stabilization services provided during the

same encounter. If the post-evaluation or post-stabilization services require an inpatient level of care, the carrier shall make a utilization review determination within 24 hours of receiving a request for those services and the carrier is responsible for payment for those services for the duration until the carrier affirmatively notifies the provider otherwise. If the utilization review determination is not made within 24 hours, the services for which the utilization review was requested are deemed approved until the carrier affirmatively notifies the provider otherwise.

Sec. A-8. 24-A MRSA §4312, first ¶, as amended by PL 2007, c. 199, Pt. B, §17, is further amended to read:

An enrollee or the enrollee's authorized representative has the right to an independent external review of a carrier's adverse health care treatment decision made by or on behalf of a carrier offering or renewing a health plan in accordance with the requirements of this section. An enrollee's failure to obtain authorization prior to receiving an otherwise covered service may not preclude an enrollee from exercising the enrollee's rights under this section.

Sec. A-9. 24-A MRSA §4312, sub-§1-A is enacted to read:

1-A. Request for independent external review by enrollee's authorized representative. A request for an independent external review may be made by an enrollee's authorized representative as defined in section 4301-A, subsection 2, paragraph D in accordance with this subsection.

A. The enrollee's authorized representative shall notify the enrollee in writing at least 14 days prior to filing a request for independent external review and within 7 days after filing the request or withdrawing the request.

B. The enrollee may affirmatively object to the request for independent external review at any time prior to the filing of a request by an enrollee's authorized representative and, after a request has been filed, may notify the bureau at any time that the enrollee intends to take the place of the enrollee's authorized representative as a party in the independent external review.

Sec. A-10. Application. This Part applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2025. For purposes of this Part, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

PART B

Sec. B-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. B-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 annually report to the superintendent the following information related to prior authorization determinations for the prior calendar year:

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 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;

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; and

J. The average and median time that elapsed between the submission of a concurrent care prior authorization request to extend a course of treatment and a determination by the carrier, aggregated for all items and services.

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

2-B. Data reporting; utilization review data. Beginning April 1, 2025 and April 1st of each year 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, and post this information on the bureau's publicly accessible website.

Sec. B-4. Reporting on data submitted by health insurance carriers on prior authorization determinations. The Superintendent of Insurance shall survey health insurance carriers in this State to request data from carriers for calendar years 2021, 2022 and 2023 that, at a minimum, provides information related to prior authorization determinations as described in the Maine Revised Statutes, Title 24-A, section 4302, subsection 2-A. No later than January 15, 2025, the Superintendent shall submit to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters a report that collects the data submitted by each carrier related to prior authorization determinations. The joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters may report out a bill to the 132nd Legislature in 2025 based on the report provided in accordance with this section.'

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

SUMMARY

This amendment replaces the bill, which is a concept draft. The amendment, which is the majority report of the committee, does the following.

In Part A, the amendment permits a provider that is actively treating an enrollee to act as an authorized representative of an enrollee for purposes of grievances and appeals of health insurance carrier decisions without requiring prior written authorization from the enrollee. The amendment does require that a provider actively treating an enrollee must notify an enrollee at least 14 days prior to filing a grievance or appeal and within 7 days after filing a grievance or appeal or withdrawing a grievance or appeal and also permits an enrollee to affirmatively object to the provider's action.

The amendment requires carriers to allow prior authorization approvals to be effective for a 2-week period before and after a specific date. It also prohibits carriers from denying claims for nonemergency services that were within the scope of the enrollee's coverage pending medical necessity review and prohibits carriers from imposing a penalty of more than 15% of the contractually allowed amount for the services that required prior authorization approval on the provider for failing to obtain a prior authorization.

The amendment prohibits carriers from making determinations of medical necessity based on whether those services are provided by participating or nonparticipating providers. The amendment also provides that, if a patient needs immediate post-evaluation or post-stabilization services, a carrier is prohibited from requiring prior authorization for those services provided during the same encounter. If post-evaluation or post-stabilization services necessitate inpatient care, a carrier is permitted to impose prior authorization for those services but carriers are required to respond to the prior authorization request within 24 hours. If the provider does not receive a determination from the carrier within 24 hours, the care is deemed approved until the carrier affirmatively notifies the provider otherwise.

The requirements of Part A apply to all policies, contracts or certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2025.

Part B requires carriers to report certain information related to prior authorization determinations and also requires the Department of Professional and Financial Regulation, Bureau of Insurance to annually report aggregate data for carriers, including posting information on the bureau's publicly accessible website.

Part B also requires the Superintendent of Insurance to collect data related to prior authorization determinations for calendar years 2021, 2022 and 2023 from health insurance carriers. It requires the superintendent to report this information to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters no later than January 15, 2025 and authorizes the committee to report out legislation based on the report to the 132nd Legislature in 2025.

FISCAL NOTE REQUIRED

(See attached)