MAINE ASSOCIATION
OF
HEALTH PLANS

Testimony of Dan Demeritt – 5/2/23
Joint Standing Committee on Health Coverage, Insurance, and Financial Services

In Opposition to LD 796
An Act Concerning Prior Authorization for Health Care Provider Services

Senator Bailey, Representative Perry, and Members of the Joint Standing Committee on Health Coverage, Insurance, and Financial Services:

My name is Dan Demeritt, the Executive Director of the Maine Association of Health Plans (MeAHP). Our plans include Anthem Blue Cross and Blue Shield, Cigna, CVS / Aetna, Community Health Options, Harvard Pilgrim Health Care, and United Health Care. Our private and non-profit insurance carriers provide or administer health insurance coverage to about 600,000 Maine people. Our mission as an association is to improve the health of Maine people by promoting affordable, safe, and coordinated healthcare.

The members of the Maine Association of Health Plans have serious concerns about the ramifications of changes proposed in LD 796. Equally concerning is the manner and rushed nature of this bill which proposes to reduce checks and balances on healthcare utilization and spending that have been diminished in recent years through legislative action.[1]

Since the draft amendment was first shared yesterday, my comments today are based on a preliminary review of the proposed amendment. I will collaborate with member plans to provide more detailed comments before your work session.

First, some context for the committee to consider.

As I have shared, the Centers for Medicare and Medicaid Services published a proposed rule in December on Advancing Interoperability and Improving Prior Authorization Processes that applies to commercial insurance carriers. [2]

Commercial insurance providers continue to modulate prior authorization processes to strike the right balance of adherence to coverage requirements with ease of access for patients and providers alike. In the best tradition of free markets and open competition, some of the nation's

[1] http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0218&item=3&snum=129

[2] https://www.cms.gov/newsroom/fact-sheets/advancing-interoperability-and-improving-prior-authorization-processes-proposed-rule-cms-0057-p-fact

largest carriers are rolling out market-informed initiatives to provide better service for all and drive change in the marketplace.[3]

Prior authorization remains a valuable tool for promoting the use of evidence-based medicine to ensure better outcomes and greater value for patients and employer-based purchasers. The impact of well-intended but wasteful over-treatment or low-value care is well documented: a 2019 study in JAMA (Journal of American Medical Association) estimates that healthcare waste accounts for 25% of U.S. healthcare spending.[4]

Insurers preparing their rate filings must protect against risk, including the unknown impact of new laws and regulations. LD 796 comes to us without an enactment date. It proposes broad curbs to utilization management just days after the Acting Superintendent of Insurance issued a June 16, 2023, uniform deadline for rate filings for the 2024 plan year. [5]

The bill we received yesterday will bring uncertainty to Maine's health insurance marketplace. Examples include the creation of a new definition in Maine statute for "closely related service" and an exemption of those services from utilization reviews.

The bill creates an exemption from utilization commonly referred to as a "gold card." The proposed 80% standard would allow for 20% of care to be unnecessary. This should concern everyone in the healthcare system. The threshold must be much higher to be considered reasonable or appropriate.

LD 796 proposes several changes to review deadlines, including a mandate that stabilization services be reviewed by carriers within 60 minutes or be deemed approved. It is unclear whether providers themselves are willing and ready to operationalize such stringent deadlines and the impact they could have on decision-making.

Moreover, shorter turnaround times can create unintended consequences. We must think carefully about how much time and information is needed to make the appropriate decision.

The continuity of care provision requires one insurer to honor a utilization determination made by another carrier for at least 90 days without any consideration of changes in circumstances.

Prior authorization reforms and process improvements are needed but are too important to be rushed through, particularly while federal rulemaking impacting 135 million Americans is underway.[6] We urge the committee to vote ONTP on LD 796. Thank you, and I would be happy to answer any questions.

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[3] https://www.wsj.com/articles/dreaded-medical-paperwork-required-by-health-insurers-to-be-trimmed-d2b3f1f5

[4] https://jamanetwork.com/journals/jama/article-abstract/2752664

[5] https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/465.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

[6] https://www.cms.gov/newsroom/news-alert/cms-releases-latest-enrollment-figures-medicare-medicaid-and-childrens-health-insurance-program-chip