HEALTHCARE
PURCHASER
ALLIANCE
OF MAINE

Testimony of Peter Hayes
to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

In Opposition to

LD 796, An Act Concerning Prior Authorizations for Health Care Provider Services

May 2, 2023

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

My name is Peter Hayes and I'm the President and CEO of the Healthcare Purchaser Alliance of Maine. The HPA is a nonprofit that represents the purchasers of healthcare in Maine. Our mission is to advance healthcare value and to support and incentivize high-quality, affordable care. We have over 60 members, including some of the largest public and private employers and health trusts in Maine. Collectively, our members spend over a billion dollars annually providing health care for nearly one quarter of the commercially insured population in the state.

I'm here today to testify in opposition to LD 796. We agree that prior authorization and utilization review processes should be as streamlined, cost-efficient, and prompt as possible, so that clinicians can focus their time on patient care. We share the concerns that committee members have raised this session about how administrative burdens contribute to the rising cost of health care in Maine. But that is not the only factor driving healthcare costs. The plan sponsors who are paying for health care need to know that there are robust processes in place to ensure that their plan dollars are supporting appropriate interventions and reasonable limits on utilization. We are concerned that some of the changes proposed in LD 796 could limit carriers' ability to reduce inappropriate and overutilization of care.

Many studies have identified waste in our healthcare system—not just administrative waste, but the provision of healthcare services that are unnecessary or inappropriate. For instance, a 2018 *Health Affairs* article estimated that nearly 8% of commercial payer dollars in 2016 was spent on overtreatment.[1] Another study of elective outpatient CT and MRIs found that 26% were not considered appropriate.[2] Even surveyed physicians said that they believed over 20% of medical care is unnecessary.[3] And it's not just employers who are paying for these inappropriate or low value services, it's also our employees and their families, who bear these costs before they reach their deductibles or through copays and coinsurance, or higher premium costs.

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[1] Daniel P. O'Neill, David Scheinker, "Wasted Health Spending: Who's Picking Up The Tab," *Health Affairs,* May 31, 2018. Available at: https://www.healthaffairs.org/do/10.1377/forefront.20180530.245587/full/.

[2] BE Lehnert and RL Bree, "Analysis of Appropriateness of Outpatient CT and MRI Referred from Primary Care Clinics at an Academic Medical Center: How Critical is the Need for Improved Decision Support?" Journal of the American College of Radiology, 2010. Available at: https://www.jacr.org/article/S1546-1440(09)00589-4/fulltext.

[3] Heather Lyu, Tim Xu, et. al, "Overtreatment in the United States," PLOS ONE, September 2017. Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970.

These unnecessary services don't just increase costs, they can also put patients through invasive surgical procedures, often with poor outcomes. When one large company offered a spine center of excellence program to its members, they found that more than one-third of referred individuals did not need back surgery.[4] And a study of the Ohio Bureau of Worker's Compensation database showed that almost 50% of patients suffering from disc degeneration, disc herniation, and/or nerve disease underwent spinal fusion surgery. Two years later, only 26 percent of patients who underwent surgery recovered enough to go back to work, while 67% of patients who did not undergo surgery were able to return to work.[5]

Some question whether prior authorizations are cost effective, once the extra administrative burden for providers is factored in. To that point, a January 2023 working paper from the National Bureau of Economic Research on prescription drug prior authorization in Medicare Part D concluded that their "results suggest that prior authorization restrictions are a powerful tool for reducing health care costs. As highlighted by the American Medical Association and other interest groups, these restrictions do also generate substantial administrative costs. However, even under generous assumptions, these administrative costs are small relative to the reductions in drug spending achieved by these restrictions."[6]

The carriers who operate these programs will be able to share more detailed feedback regarding the impact of the changes proposed in the bill, and we urge you not to pursue changes that would limit their ability to utilize these cost-effective tools to minimize inappropriate and overutilization of care. For instance, LD 796 would prohibit utilization review of a service delivered by a provider if at least 80 percent of the provider's utilization review requests for that service over the last 12 months had been approved. That means that a provider who has one out of every five services rejected under utilization review would be exempt from any further utilization review for that service—apparently in perpetuity. Further, we're only aware of one other state that has enacted a similar policy, and in that state, the threshold for exemption is 90 percent.[7] If the committee wants to consider exemptions for providers with high approval rates, we suggest setting the rate above 80 percent—which I believe would earn you a grade of C at most Maine high schools.

As we try to lower the costs of health care in Maine, we believe one of the first areas we should focus on is services that are unnecessary or inappropriate. To that end, as the committee evaluates the many changes proposed in LD 796, we urge you to focus on modifications that would streamline administration without restraining carriers' ability to effectively limit inappropriate and over-utilization of care.

I'd be happy to answer any questions and will be available for the work session.

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[4] Laura Dyrda, "Wal-Mart adds Mayo Clinic to spine centers of excellence, 50% copay for out-of-network care," *Becker's Spine Review,* November 16, 2016. Available at: https://www.beckersspine.com/spine/33671-walmart-adds-mayo-clinic-to-spine-centers-of-excellence-50-copay-for-out-of-network-care.html.

[5] Ohio Bureau of Workers' Compensation, "4123-6-32 Appendix: What BWC Wants You to Know About Lumbar Fusion Surgery, https://www.bwc.ohio.gov/downloads/blankpdf/OAC4123-6-32Appendix.pdf. As found in: Keven Pauza, "Why is Ineffective & Unnecessary Spine Surgery So Common?" Available at: https://drkevinpauza.com/unnecessary-spine-surgery/. OR https://uccenters.com/why-back-surgery-may-be-unnecessary-or-ineffective/.

[6] Zarek C. Brot-Goldberg, Samantha Burn, Timothy Layton, and Boris Vabson, "Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare," Working Paper 30878, *National Bureau of Economic Research*, January 2023. Available at: https://www.nber.org/system/files/working_papers/w30878/w30878.pdf.

[7] Andrew Cass, "Texas physician 'gold card' rules take effect Oct. 1," Becker's Hospital CFO Report, September 20, 2022. Available at: https://www.beckershospitalreview.com/finance/texas-physician-gold-card-rules-take-effect-oct-1.html.