TESTIMONY OF JOANNE RAWLINGS-SEKUNDA
DIRECTOR, CONSUMER HEALTH CARE DIVISION
BUREAU OF INSURANCE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

In support of L.D. 270

Resolve, Regarding Legislative Review of Portions of Chapter 850 Health Plan Accountability, a Major Substantive Rule of the Department of Professional and Financial Regulation, Bureau of Insurance

Presented by Representative Kristi Mathieson

Before the Joint Standing Committee on Health Coverage, Insurance & Financial Services

February 12, 2025 at 10:00 a.m.

Senator Bailey, Representative Mathieson, and members of the Health Coverage, Insurance and Financial Services Committee, I am Joanne Rawlings-Sekunda, Director of the Bureau of Insurance's Consumer Health Care Division. I am here today to testify in support of LD 270.

As Rep. Mathieson explained, this resolve approves changes made to the Bureau of Insurance's Rule Chapter 850, Health Plan Accountability. The rule is being amended for three reasons:

The first is to reflect amendments made to the Health Plan Improvement Act as enacted by P.L. 2021, Chapter 603 and P.L. 2023 Chapter 680. The first amendment made changes to the provider credentialing requirements in section

4303(2)(D) of the Maine Insurance Code to ensure that carriers act on a provider credentialing application within the required 60-day period without impacting quality or accreditation standards. The other amendment revised the definition of "authorized representative" to include an actively treating provider, which gives the provider the right to request an appeal on behalf of a patient, unless the patient revokes the authorization. It also revised the requirements governing the prior authorization process, including adding a denial of a prior authorization to the statutory definition of "adverse health care treatment decision."

Second, the Rule has been amended to address new federal network adequacy requirements adopted by the U.S. Department of Health and Human Services through its Notice of Benefits and Payment Parameters for 2025 (NBPP), which sets standards for carriers offering policies on health insurance marketplaces, including the Maine marketplace, CoverME.gov. Since the federal standards may change from year to year, section 7(B)(2) was amended to remove (except for primary care services) the existing network adequacy requirements and direct the BOI to publish on its website annually the standards for network adequacy and the exemption process mandated by the NBPP. The NBPP makes those new standards effective on January 1, 2026.

Lastly, the rule contains minor changes suggested by staff to clarify inconsistencies, remove irrelevant language, and add language that was overlooked the previous times we opened the rule. These changes include the addition of pharmacy benefits managers that conduct utilization review to the definition of "utilization review entity," to reflect the inclusion of the ability to provide these

services within the statutory definition of "pharmacy benefits manager" at 24-A M.R.S. § 4347(17).

The Bureau requests one additional change not reflected in the provisionally adopted rule. Current sections of Rule 850 require carriers to provide the name and title of the person or persons evaluating a claims appeal. In response to personnel safety concerns expressed by insurers in the aftermath of UnitedHealthCare CEO's murder in December (which occurred after the rule was provisionally adopted), the Bureau has temporarily suspended this requirement for the safety of those who make decisions on appeals. On January 24, 2025, the Bureau issued Bulletin 482 (attached), informing insurance companies subject to Rule 850's notice requirements of the Superintendent's decision to suspend enforcement of these identification provisions.

The Bureau suggests that the Committee review and amend these portions of the rule so that the intent of this transparency requirement is preserved but with changes to protect the identity of the reviewer from disclosure. Our recommendation is to require the credentials of the reviewer, an attestation that the reviewer did not participate in the initial decision, and a point of contact to answer specific questions from the insured.

I would be happy to answer any questions now or at the work session.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
BUREAU OF INSURANCE

Janet T. Mills
Governor

Joan Cohen
Commissioner

Robert L. Carey
Superintendent

Bulletin 482

Suspension of Enforcement of Certain Provisions of Rule Chapter 850

The Superintendent of Insurance has decided to suspend enforcement of certain provisions of Bureau of Insurance Rule Chapter 850 that require insurance companies offering health plans in Maine to include employee names and titles on notices of consumer appeal decisions.[1]

This decision stems from employee safety concerns raised by insurance companies that are subject to Rule 850's notice requirements. Accordingly, we are not currently enforcing the requirement in Rule 850 § 8(G)(1)(c)(i) that health care treatment appeal decisions include "[t]he names, titles and qualifying credentials of the person or persons evaluating the appeal" or the requirement in Rule 850 § 9(B)(2)(b)(i) that benefit denials that do not involve health care treatment decisions include "[t]he names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers)."

Although enforcement of these identification provisions is suspended, insurance carriers are still required to note the qualifying credentials of the person(s) evaluating the appeal and attest that the appeal reviewer was not involved in the initial adverse determination, unless additional information not previously considered during the initial review is provided on appeal.

Carriers are also still required to provide consumers with the name, address, and telephone number of a person within the company who has been designated to coordinate their appeals. This information is provided in the letter insurance companies send to acknowledge receipt of a consumer appeal.[2]

Carriers must continue to ensure that any Maine consumer who contacts them about an appeal denial notice will be able to reach a company employee with knowledge of the appeal. This person should be able to discuss the appeal's status and provide any next steps a consumer may need to take.

[1] These requirements of Rule 850 and this suspension of enforcement apply only to "carriers" offering "health plans" as those terms are defined in 24-A M.R.S. § 4301-A.

[2] See Rule 850 §§ 8(G)(1)(iv) and 9(B)(2).

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Amendments to Rule 850 are under consideration by the Maine Legislature, and we plan to raise this issue with the Health Coverage, Insurance and Financial Services Committee. This suspension of enforcement will remain in place until further notice.

January 24, 2025

Robert L. Carey
Superintendent of Insurance

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