MeAHP
MAINE ASSOCIATION OF HEALTH PLANS

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Testimony In Opposition to LD 582
An Act to Require Health Insurance Carriers to Provide Coverage for Blood Testing for Perfluoroalkyl and Polyfluoroalkyl Substances
March 4, 2025

Senator Bailey, Representative Mathieson, and Members of the Health Coverage, Insurance, and Financial Services Committee.

My name is Dan Demeritt, the Executive Director of the Maine Association of Health Plans. Insurance coverages offered or administered by our member plans provide access to care and better outcomes for many of the Mainers who receive coverage through an employer plan or the individual market. Our mission as an association is to improve health by promoting affordable, safe, and coordinated health care.

Testing for PFAS exposure is generally considered investigatory and not medically necessary for all indications. Nevertheless, coverage for PFAS testing may be provided by carriers when there is clinical utility tied to the screening.

We oppose LD 582 as drafted for the following reasons:

Public Health Screening Program For PFAS Exposure – Section 1, proposed §4320-W: We oppose LD 582 because it essentially seeks to create a public health screening program for PFAS exposure that will increase the costs of health insurance premiums for consumers, employers, and taxpayers. Maine's insurance code is not the place to establish or fund public health initiatives.

2022 NAS Guidance Developed to Inform ATSDR – Section 1, proposed §4320-W(2): The 2022 National Academy of Sciences (NAS) Clinical Guidelines referenced in the bill advises the U.S. CDC's Agency for Toxic Substances and Disease Registry (ATSDR) to change its guidance to say that clinicians should offer PFAS blood testing to patients likely to have a history of elevated exposure to PFAS while acknowledging, ***"...this information cannot indicate or predict how likely it is that an individual will end up with a particular condition."***[1]

To date, ATSDR has not made this change to its recommendations.

2024 ATSDR Guidance – No Treatment Or Prediction of Future Health Problems: ATSDR's current guidance for consumers notes that PFAS blood testing results will tell you how much of certain PFAS are in your blood, but they will not:

- Provide clear information about possible health effects.
- Pinpoint a health problem.
- Provide information for treatment.
- Predict or rule out future health problems due to exposure.[2]

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[1] https://nap.nationalacademies.org/resource/26156/PFAS%20Guidance%20Highlights.pdf, p.3
[2] https://www.atsdr.cdc.gov/pfas/blood-testing/index.html. Accessed 3/4/25

According to the fact sheet included with my testimony, ATSDR has not developed health-based blood screening levels for PFAS.[3]

Prohibition on Cost Share – Section I.3
This section of the bill creates first-dollar coverage for PFAS testing, providing 100% coverage for PFAS screening with no diagnostic value while other diagnostic tests are subject to cost share.

Defrayal Determination and Risk To Federal Funding – Section 2
As the Bureau of Insurance shared last year when similar legislation was considered, a new PFAS testing mandate requires defrayal. A legislative finding determining otherwise would be unprecedented and could jeopardize state funding.

The Bureau's May 9, 2024, memo is provided.

In addition, guidance issued by CMS[4] makes it clear that states do not have the discretion to determine whether a mandate requires defrayal:

Q2: May states use their discretion in determining whether a state mandate requires defrayal?

A2: No. We remind states that, although it is the state's responsibility to identify which state required benefits require defrayal, states must make such determinations using the framework finalized at §155.170, which specifies that benefits required by state action taking place on or before December 31, 2011, may be considered EHB, whereas benefits required by state action taking place after December 31, 2011, other than for purposes of compliance with federal requirements, are in addition to EHB and must be defrayed by the state. For example, a law requiring coverage of a benefit passed by a state after December 31, 2011, is still a state mandated benefit requiring defrayal even if the text of the law says otherwise.

Based on the reasons stated, we recommend a vote of ought not to pass on LD 582.

If the committee advances the bill, we recommend needed improvements:

- Section 1: **proposed §4320-W(2):** Strike the reference making the presumption of medical necessity based on the NAS report and instead require coverage for those with an elevated risk of exposure.

- Section 1: **proposed §4320-W(3):** Stike the prohibition on cost sharing.

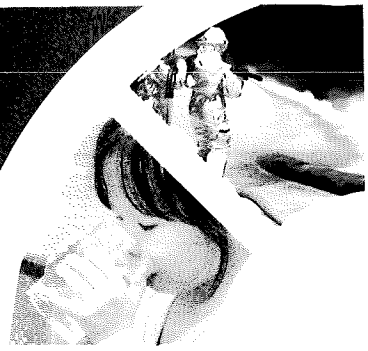
- Section 2: Strike this section and consider a letter to the Bureau of Insurance raising the issue of whether medically necessary PFAS testing should be included in the update to Maine's Essential Health Benefits.

Thank you for your consideration.

[3] https://www.atsdr.cdc.gov/media/pdfs/2024/07/ATSDR-PFAS-Information-for-Clinicians.pdf
[4] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf

PFAS

Information for Clinicians



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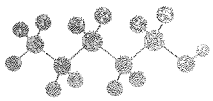


- Per- and polyfluoroalkyl substances (PFAS) are a family of thousands of synthetic chemicals; relatively few have been studied for their effect on health
- Used widely to reduce friction or resist oil, water, and stains
- Widespread and persistent in the environment
- Among studied PFAS: absorbed in intestines and lungs; bind to serum and tissue proteins; most not metabolized; half-lives range from a few days to 8+ years

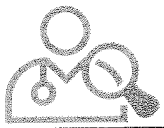
Human Exposure

- Nearly all people in the U.S. have had exposure to PFAS
- PFOS, PFOA, and PFHxS exposure is decreasing in the U.S. population, in part because of production phase-outs
- Population exposures to substitute PFAS (e.g., GenX) are not well studied
- Communities with PFAS contamination of water or food are often near facilities that have manufactured, used, or handled PFAS
- Ingestion of PFAS in water and food is a main route of exposure; ingestion of dust and residue from PFAS-containing products can also result in exposure
- Inhalation is not a typical route of exposure for the general population but can occur with PFAS-containing dust, aerosols, or fumes
- Children can be exposed by drinking formula mixed with PFAS-containing water, drinking breastmilk from persons exposed to PFAS, ingesting dust or dirt, and through hand to mouth behaviors with textiles treated with stain protectants
- Some PFAS cross the placenta and enter umbilical cord blood

Health Effects

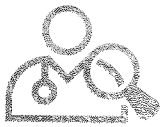
- Research is ongoing to understand the mechanisms of PFAS toxicity
- The epidemiological evidence suggests associations between increases in exposure to (specific) PFAS and certain health effects
  - Increases in cholesterol levels (PFOA, PFOS, PFNA, PFDA)
  - Small decreases in birth weight (PFOA, PFOS)
  - Lower antibody response to some vaccines (PFOA, PFOS, PFHxS, PFDA)
  - Kidney and testicular cancer (PFOA)
  - Pregnancy-induced hypertension or preeclampsia (PFOA, PFOS)
  - Changes in liver enzymes (PFOA, PFOS, PFHxS)
- The risk of health effects associated with PFAS depends on
  - Exposure factors (e.g., dose, frequency, route, and duration)
  - Individual factors (e.g., sensitivity and chronic disease burden)
  - Other determinants of health (e.g., access to safer water and quality healthcare)

Clinical Evaluation and Management



- Main goals are to
  - Identify and reduce PFAS exposures
  - Promote standard age-appropriate preventive care measures for physical health, mental health, and wellness
- Clinical presentation: PFAS toxicity is not associated with characteristic signs or symptoms
- Taking an exposure history can help identify PFAS exposures and determine actions to reduce exposures; ask about possible current and past PFAS exposure sources, durations, frequency, and magnitude

Clinical Evaluation and Management *(continued)*



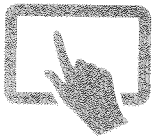
Highlights Added for MeAHP Testimony on LD 582 3/4/25

- Exposure reduction strategies follow from the exposure history; examples include
  - Installing water filtration system or using an alternative water source
  - Limiting or avoiding consumption of contaminated fish, meat, eggs, or dairy
  - Choosing products without PFAS when possible
- Breastfeeding is optimal due to its many benefits; clinicians can assist patients in their decision to breastfeed based on factors specific to the patient and child
- Clinicians can counsel patients on whether to pursue blood testing with an understanding of the benefits and limitations of PFAS testing:
  - Results (current levels of PFAS in the blood) could reflect recent exposures or past exposures in the case of PFAS with long half-lives
  - PFAS blood test results do not identify sources of exposure
  - Results do not indicate whether a current illness can be attributed to PFAS exposure or predict future health problems
  - Comparing PFAS results across laboratories can be difficult
  - Potential relief from psychological distress if PFAS levels are normal
  - Having information that could guide exposure reduction decisions
  - Potential for false positives from screening based on PFAS blood test results and iatrogenic complications from additional evaluation and treatment
- ATSDR has not developed health-based screening blood levels for PFAS
- No approved medical treatments are available to remove PFAS from the body

Additional Expertise

- Other professionals can help with exposure histories and reduction methods, and patient evaluation and monitoring/treatment plans:
  - Board-certified clinicians specializing in occupational and environmental medicine, medical toxicology, and pediatric environmental health
  - Occupational health clinicians
  - State or local health/environmental departments

More Resources



- **ATSDR PFAS Information for Clinicians (full document)**
- American College of Medical Toxicology
- Association of Occupational and Environmental Clinics
- ATSDR Toxicological Profile for PFAS
- ATSDR PFAS and Your Health
- ATSDR PFAS Blood Level Estimation Tool
- ATSDR Minimal Risk Levels for PFAS
- CDC's Breastfeeding: Why it Matters
- CDC National Report on Human Exposure to Environmental Chemicals
- EPA's Meaningful and Achievable Steps You Can Take to Reduce Your Risk
- NASEM Guidance on PFAS Testing and Health Outcomes
- National Institute for Occupational Safety and Health PFAS webpage
- Pediatric Environmental Health Specialty Units

Acronyms:

PFAS: Per- and polyfluoroalkyl substances
PFDA: Perfluorodecanoic acid
PFHxS: Perfluorohexane sulfonic acid
PFNA: Perfluorononanoic acid
PFOA: Perfluorooctanoic acid
PFOS: Perfluorooctane sulfonic acid

CDC ATSDR
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
Agency for Toxic Substances and Disease Registry

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

Janet T. Mills
Governor

Anne L. Head
DPFR Commissioner

Robert L. Carey
Superintendent

MEMORANDUM

Shared by MeAHP with Testimony on LD 582, 3/4/25. Highlights added for emphasis.

To: Members of the 131st Legislature

From: Robert L. Carey, Superintendent, Bureau of Insurance

Date: May 9, 2024

Re: Defrayal costs of mandated benefits

This memo is in response to amendments to L.D. 132 and L.D. 1577. While we have not seen the final language related to these bills, we are concerned about any amendments that remove the mandated benefits defrayal costs from the fiscal note and add a statement of legislative finding that the insurance coverage for the testing required by each bill is not a new mandate that requires defrayal.

Federal law requires defrayal payments for mandates that are not covered under the state's "benchmark plan".[1] The Bureau of Insurance works with the Centers for Medicare and Medicaid Services (CMS) to determine which new mandated benefits may require defrayal. In this instance, *Bureau staff met with CMS staff in November 2023, and CMS staff indicated that because L.D. 132 and L.D. 1577 require a specific type of testing that is not required by federal law, the mandate, if enacted, will likely require the state to defray the cost for people purchasing coverage through CoverME.* The testing described by each of these bills is not currently covered by Maine health insurers as part of the benchmark plan and it is not required by federal law, therefore it would likely require defrayal. To legislatively declare that a mandated benefit does not require defrayal is problematic for the following reasons:

> **The mandate requires defrayal.** For biomarker testing, Kentucky has a similar mandate and the state, in consultation with CMS, determined it required defrayal. In contrast, Arizona determined their biomarker mandate does not require defrayal because the diagnostic testing benefit in Arizona's benchmark already included biomarker testing due to its broad language in that state's benchmark plan. Because each state's benchmark plan may differ, the determination for each state varies. Only one other state, New Hampshire, has passed legislation requiring coverage for PFAS blood testing. Their mandate was considered a clarification of existing lab testing coverage. *For Maine, as stated above, the Maine BOI consulted with CMS, and CMS indicated that both of these benefits will likely require defrayal.* Contrary to misinformation that has been spread, other states pay defrayal costs. At least three states are currently making defrayal payments. According to the National Association of Insurance

[1] 45 CFR 155.170

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Commissioners (NAIC), Massachusetts, Utah and Minnesota are currently making defrayal payments. Virginia and New Mexico passed laws last year and expect to make defrayal payments related to those laws. The federal government has recently increased interest in the area of defrayal. The US Government Accountability Office has reached out to the Bureau of Insurance regarding state-mandated benefits in Maine's Marketplace plans. Specifically, the request asks what the mandated benefits subject to defrayal include, how the payments are or will be made, and the actual or estimated amounts of those payments.

To our knowledge, no other state legislature decides whether a new mandated benefit requires defrayal. In every other state, an agency tasked with regulating health insurance plans, either the insurance department or the entity that runs the state's health insurance exchange, makes the decision about defrayal. This is a function of executing the preemptive federal law. The Office of the Attorney General has communicated agreement with the position that while the legislature is free to take or ignore the advice of the Bureau, failure to follow the Bureau's guidance may result in litigation.

To ignore the determination made by the Bureau and CMS could have follow-on effects that jeopardize federal funding. Carriers report the amount of premium they charge and the amount they estimate spending on new mandated benefits that require defrayal. Since the defrayal amount is not included in the monthly premiums charged by the carriers, the carriers expect to recoup the cost of providing mandated benefits through defrayal reimbursement payments made by the state. If the state does not cover the cost of mandated benefits subject to defrayal, it is likely the carriers will seek compensation through the courts.

In addition, defrayal payments are taken into consideration to determine the amount of federal pass-through funding that is made available for the state's reinsurance program in the individual and small group market. This pass-through funding lowers the premiums for consumers and employers. In 2024, that amount is $45,726,151. Should CMS become aware that Maine is not providing the required defrayal payments but rather including the cost of these benefits in the premiums charged consumers, CMS could reduce the amount of federal pass-through funding provided. This would adversely affect the premium rates of every individual and small group plan in the merged (individual and small group) market.

The Bureau does not object to requiring coverage for PFAS testing or biomarker and takes no position on the ongoing funding, we only object to the legislative finding about the defrayal cost and the removal of the fiscal note. In order to continue to follow federal law, as required of Maine and every other state, the Bureau urges that L.D. 132 and L.D. 1577 not be amended to remove the defrayal costs nor amended to add a legislative finding about newly enacted mandated benefits not being subject to defrayal. We believe this type of legislative overreach will set an unfortunate and ill-advised precedent with direct consequences to the state's reinsurance program.

Please do not hesitate to contact me if you have any questions or would like additional information. I appreciate your assistance in this matter.