MeAHP
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Testimony in Opposition to LD 910

An Act to Collect Data to Better Understand the Consumer's Health Insurance Experience

April 8, 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.

LD 910 duplicates annual data reporting requirements already included in Maine law, adds to the administrative burden of Maine carriers and the Maine Bureau of Insurance by requiring that data currently submitted annually be shared quarterly, and calls for annual reporting that is already being provided by the Bureau.

Existing and Recently Updated Health Insurance Carrier Reporting

Health insurance carriers with more than 1,000 Maine covered lives must adhere to reporting requirements included in 24-A MRSA §4302.

The Bureau recently updated its Health Care Survey and Prior Authorization Report Instructions following the passage of prior authorization legislation in the 131st Legislature (LD 796).[1] We understand that the Bureau will use these data to integrate its health care survey and prior authorization reporting into one legislative report beginning in 2026.

The first annual filing deadline for the data was April 1, 2025. The instructions the Bureau provided to carriers are provided with my testimony. The request for information includes:

- Twenty detailed questions about prior authorization results and processing times.
- Eight detailed questions about complaints, appeals, and grievances.
- Five questions about plan disenrollment data and reasons for disenrollment.
- Requests for Consumer Assessment of Health Plans Survey results.

LD 910 is redundant and creates new administrative burdens. We urge a vote of Ought Not to Pass on the bill.

[1] https://legislature.maine.gov/billtracker/#Paper/HP0485?legislature=131

2) Number of requests for all authorizations, including prospective and concurrent authorization requests (also known as reauthorization requests).
3) Number of reauthorization requests for ongoing care that were approved, aggregated for all items and services.
4) Number of reauthorization requests for ongoing care that were denied, aggregated for all items and services.
5) Number of standard prior authorization requests that were approved, aggregated for all items and services.
6) Number of standard prior authorization requests that were denied, aggregated for all items and services.
7) Number of prior authorization requests that were approved after the timeframe for review was extended based on the need for outside consultation, aggregated for all items and services.
8) Number of prior authorization requests that were denied after the timeframe for review was extended based on the need for outside consultation, aggregated for all items and services.
9) Number of prior authorization requests that were approved after the timeframe for review was extended based on a carrier request for additional information, aggregated for all items and services.
10) Number of prior authorization requests that were denied after the timeframe for review was extended based on a carrier request for additional information, aggregated for all items and services.
11) Number of denied standard prior authorization requests that were approved after appeal, aggregated for all items and services.
12) Number of denied standard prior authorization requests that were denied after appeal, aggregated for all items and services.
13) Number of expedited prior authorization requests that were approved, aggregated for all items and services.
14) Number of expedited prior authorization requests that were denied, aggregated for all items and services.
15) Number of denied expedited prior authorization requests that were approved after appeal, aggregated for all items and services.
16) Number of denied expedited prior authorization requests that were denied after appeal, aggregated for all items and services.
17) Average and median time that elapsed between receiving all necessary information following the submission of a standard prior authorization request and a determination by the carrier, aggregated for all items and services.
18) Average and median time that elapsed between the submission of an expedited prior authorization request and a decision by the carrier, aggregated for all items and services, and
19) Average and median time that elapsed between receiving all necessary information following the submission of a concurrent care reauthorization request to extend a course of treatment and a determination by the carrier, aggregated for all items and services.
20) The number of prior authorizations in which the services requested or performed include chiropractic services.

The percentages in this section will be calculated automatically based on the numbers submitted.

Section IV: Complaints, Appeals, and Grievances

1) The ratio of the total number of complaints (all grievances and appeals combined) received to the total number of enrollees, reported by the following categories:
    a. Claim denials/delays
    b. Medical necessity of care
    c. Accessibility of care
    d. Behavioral Health
    e. Chiropractic services
    f. Non-renewals/termination
    g. All other issues
2) The ratio of the number of adverse benefit determinations issued to the number of complaints (all grievances and appeals combined) received, reported by the type of adverse benefit determination involved.
3) The number and ratio of the total number of successful enrollee appeals to the total number of appeals filed broken out by the type of appeal. Please include first level, second level, and external reviews combined in this calculation.
4) The number of first level appeals, and the number overturned in favor of the enrollee at first level.
5) The number of first level appeals that were appealed to the second level, and the number that were overturned at second level in favor of the enrollee.
6) The number of complaints (all grievances and appeals combined) related to chiropractic services.
7) Total number, amount and disposition of any malpractice claims settled by the carrier.
8) The number of lawsuits filed by enrollees over adverse benefit determinations.

Section V: Disenrollments

1) The number of enrollees (including dependents) who disenrolled from a plan voluntarily.
2) The five most common reasons stated by these enrollees for their disenrollment.
3) The number of enrollees who disenrolled from a plan involuntarily.
4) The number of providers who disenrolled from the carrier.
5) The five most common reasons stated by these providers for their disenrollment.

Section VI. Enrollee Satisfaction

1) Does the carrier conduct surveys among enrollees (yes/no) using the Consumer Assessment of Health Plans Survey? If yes, please provide a copy of the results. If no, how does the carrier gauge enrollee satisfaction? Please provide the results obtained through these methods.

2) Please provide a provider-to-enrollee ratio broken out by geographic region and medical specialty.

3) What actions, if any, has the carrier taken as a result of collecting and analyzing enrollee satisfaction data?

Definitions

- "Standard" means a non-expedited review.
- "Expedited" means an expedited review for a service or a prescription drug when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.
- "Concurrent" or "Reauthorization" means a review conducted during a patient's hospital stay or course of treatment.
- "Adverse benefit determination" has the same meaning as Rule 850 § 5(A) and includes both medical and non-medical determinations.
- "Prospective review" means utilization review conducted prior to an admission or a course of treatment. Rule 850 § 5(HH).
- "Grievance" has the same meaning as in Rule 850 § 5(S) and means a written complaint (including complaints submitted via e-mail), submitted by or on behalf of a covered person regarding:
    1) The availability, delivery or quality of health care services, including a complaint regarding an adverse health care treatment decision made pursuant to utilization review;
    2) Claims payment, handling or reimbursement for health care services;
    3) Matters pertaining to the contractual relationship between a covered person and a health carrier; or
    4)Adverse benefit determinations.

All information should be reported for the prior calendar year (January 1-December 31)

If you have questions about the content of the report, please contact Pamela Stutch at (207) 624-8458 or at pamela.stutch@maine.gov.

Please submit the report in Excel format to keith.a.fougere@maine.gov