TESTIMONY OF STACY BERGENDAHL

SENIOR STAFF ATTORNEY

BUREAU OF INSURANCE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

In opposition to L.D. 1496

An Act to Ensure Ongoing Access to Medications and Care for Chronic Conditions and Conditions Requiring Long-term Care by Changing Requirements for Prior Authorizations

Presented by Representative Zager

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

April 24, 2025 at 1:00pm

Senator Bailey, Representative Mathieson, and members of the Committee, I am Stacy Bergendahl, Senior Staff Attorney at the Bureau of Insurance. I am here today to testify in opposition to LD 1496.

The Bureau occasionally hears from consumers with chronic conditions expressing their unhappiness at annual (or more frequent) prior authorizations for previously approved medications, so we understand the bill sponsor's intent. However, we have several concerns with the bill and believe passage would increase health insurance premiums at a time when insurance costs are already beyond the reach of far too many Mainers.

First, the bill would require that an approved prior authorization for the treatment of a chronic condition or a "condition requiring long-term care" must remain valid for the duration of the treatment or for one year, whichever is longer. If the patient's treatment extends beyond one year, the carrier may not require prior authorization renewal more frequently than once every five years. This requirement would apply even if more effective and less costly treatment alternatives become available over the course of these five years.

Second, the bill requires a 90-day continuation of a prior authorization if the consumer enrolls with a different carrier, and the bill requires the new carrier to provide at least 90-days' notice before a new prior authorization can be undertaken. This would be difficult for carriers to implement, and difficult for the Bureau to enforce absent a market conduct examination.

Third, the provision making a new prior authorization effective when the enrollee receives notice is problematic if a prior authorization is back-dated to cover services already rendered.

Finally, Section 2 makes the bill's 90-day transitional authorization for new enrollees applicable to all medications, not just those that treat certain conditions.

All of these provisions could have a negative impact on premiums.

In addition to these substantive issues, the bill has numerous technical drafting problems:

- Some provisions refer to a "utilization review entity" (URE) when the intent appears to include carriers that perform their own utilization review. This should be changed to "carrier," or, if the intent is to make the

provisions directly enforceable against UREs, to "carrier or utilization review entity."

- Some of the bill's references to a "health plan" *(i.e.* the policy language) should be changed to "carrier": the requirements for prior authorization are contained in the terms of the health plan, but only a carrier (or a URE acting on behalf of a carrier) can grant or deny a prior authorization.
- "Rescind" is the wrong verb to use for the termination of a prior authorization for an unlawful dosage of a drug, as it implies that reimbursement could be denied for drugs already dispensed in reliance on the authorization.
- The language in the bill could be read as limiting the scope of the provision to "approval under a previous health plan within 90 days of enrollment in the new health plan." At best, it is ambiguous.
- The references to "a condition requiring long-term care" suggest that the bill is referring to treatment in a long-term care facility, which does not appear to be the intent.
- There is a conflict between the provision making a prior authorization valid for the duration of any treatment and the provision allowing a carrier to require renewal every five years.

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